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Helping our Nursing Sisters

In a recent letter from one of our nursing sisters, now serving in Europe, these very significant sentences occur: "Our greatest problem is that of reading material. If there are any more sisters who go to you before coming over, would you please tell them to subscribe to several of their favorite magazines".

There is in this message a real challenge to alumnae associations, local registered nurses associations, and to individual nurses in all parts of Canada. What are we doing to help our colleagues on the battle-fronts refresh their minds in their off duty hours? We have all contributed to book funds for the soldiers but how much have we spent on reading matter for our own colleagues? Perhaps we have taken it for granted that they are subscribing to their own magazines and don't need our help. Some of them are, no doubt, but how long does it take us to read one magazine? If we want something new to read, we can step down to the nearest drug-store and pick up what we wish to read — in English, not in Flemish or French or Italian, etc.

What can we do? The post office authorities refuse to accept parcels of magazines or newspapers going to our nursing sisters. The only way they can be sent is through a subscription directly to the publisher. Books, however, may be sent through the mails and there is an infinite variety of books available in pocket-size editions ranging all the way from cook-books to the most grisly "who-dunits". If by any remote chance you do not know the addresses of any individual nursing sisters, the copies could be sent in care of the matrons of the various units.

You will be glad to know that complimentary copies of *The Canadian Nurse* are sent each month to every one of the units overseas. The nurses are beginning to be concerned about "the problem of finding work for ourselves after the war is over". This correspondent con-

tinues: "There is a great deal of discussion going on but most people over here are a little doubtful about the future". The *Journal* is publicizing the plans and activities of the Postwar Planning Committee of the Canadian Nurses Association. For their help and guidance, see that individual copies of the *Journal* reach the graduates from your School of Nursing or the girls from your town.

The plans we may evolve are long overdue—but don't let us waste time in recriminations! Let us get a wealth of reading material flowing to our nursing sisters.

—M.E.K.

Good Luck to the New Graduates

Within the next few weeks nurses in all parts of Canada will be completing their university post-graduate courses and beginning their work as public health nurses, as instructors or supervisors in schools of nursing, or as administrators in hospitals. There will be very mixed feelings, for the year which is concluding, while it has meant strenuous study and concentration has also given an opportunity for the welding of many new friendships and inspiring discussions. As the last examination papers are handed in, the last essays and assignments completed, a concerted sigh of relief will rise as some, nay most, of the students will solemnly vow that those were the very last examinations they would ever write!

The months immediately preceding the end of the term also contain many moments of thought and consultation regarding the next step—the job. Quite a few of the students will be returning to positions from which they were released for study. But for the majority, this post-graduate training has opened a new field, and these will be weighing the relative values of this position as compared to service with that agency. Since opportunities are plentiful, applications will be filed with a variety of organizations or hospitals. Of course only one position *can* be accepted. Here, the operation of the golden rule — do as you would be done by — can ensure continued cordial relationships if the nurse will take the trouble to notify other agencies where her application is pending when she has accepted a position. It may appear a very small matter to her but it may cause considerable disruption when half a dozen or more nurses neglect this courtesy.

Quite a large proportion of the incipient graduates from university courses have been the recipients of bursaries or scholarships. With the acceptance of this award last Fall, these nurses obligated themselves to make a definite return in the form of service. On these, then, will rest the ethical responsibility of fulfilling the terms of their contract. It is indeed a tribute to the integrity of the nurses that of the hundreds who have received some form of financial assistance, a number so small as to appear negligible have failed to live up to their obligations. It is a curious reflection on human nature that we hear of these defaulters but pass by the overwhelming majority who have not failed.

To all of these new workers the *Journal* extends heartiest good wishes for success in their chosen field. Remember, there is plenty of room on top for those who scale the ladder.

—M.E.K.

Family Allowances—A Children's Charter for Canada

GEORGE F. DAVIDSON, Ph.D.

Twice in the past twenty-five years the searchlights of science and war have been turned on the standards of living in the western world. They have been found seriously wanting for great numbers of people in even the most favoured countries, as the startling number of medical rejections for military service testify.

Nations have come to realize that without a healthy and vigorous people there can be no prosperity. On an increasing scale they are devising and instituting measures of economic and social betterment to combat what Sir William Beveridge has called the wicked giants of Idleness, Want, Disease, Ignorance and Squalor. The devices are various but interdependent. Decent housing conditions and greater educational opportunities will help to defeat Squalor and Ignorance. The remedy for Idleness lies in full employment, that is, in maintaining and expanding production, ,on the one hand; on the other, in maintaining a steady flow of consumer purchasing power — regular spending on food, clothing and other necessities of life. Health services for everyone will combat disease, but in themselves cannot develop a healthy people unless Want is disposed of; unless a minimum standard of health and decency can be maintained at all times.

In Canada a forthright attack has been made upon Want by the Family Allowances Act which will place $250,000,000 in Canadian homes each year. Beginning in July, cash allowances will be paid monthly from general tax revenues towards the maintenance, care and upbringing of all children under sixteen living in a family unit. There are thus two questions to answer: Why have family allowances been chosen as the spearhead for the post-war development of economic and social security? What benefits will accrue to justify this redistribution of income?

In any structure of social security family allowances occupy a key position because of the multiple purpose they serve. The heart of the family allowance scheme lies, perhaps, in its attack on individual poverty to the extent that this grows out of factors in the wage system. Wages bear no relation to the size of the wage-earner's family. They are paid roughly on the basis of his training, skill, and the type of work performed. A married person obviously cannot rear and educate healthy children on a wage sufficient for only one person. The present necessity to do just that has forced many families below the poverty line. It must be clearly understood, however, that family allowances are not tied to the wage system, and do not limit collective bargaining. They are not a substitute for fair wages. Family allowances lessen the inevitable inequalities that cannot be met by wage adjustments. They assist parents in proportion to their family responsibilities. Family allowances are, in short, a recognition by the state that children are a national asset, and that, in the national self-interest, they must be given the protection of decent and healthful living conditions.

Furthermore, the allowances promote the prosperity of the country as a whole by placing increased purchasing power[1] in the hands of families most in need of the basic commodities of food, clothing and shelter. Expenditures on consumers' goods make up a very large

[1] "The first cause of hunger and malnutrition is poverty. It is useless to produce more food unless men and nations provide the markets to absorb it". United Nations Conference on Food and Agriculture.

proportion of our national income. Food alone is the most important single trade commodity and constitutes one-third of the cost of living. Two hundred and fifty million dollars represent a good deal in the way of food, clothing and services on the domestic market. Its regular circulation, year in and year out, will stimulate the demand for goods, and contribute to the creation and maintenance of a high level of employment.

These practical social and economic returns on money invested in family allowances are recognized by many countries of widely differing political and economic structure. Some form of family allowances has been introduced in over thirty countries, including the sister dominions, New Zealand and Australia. The British government has promised to establish them immediately after the war as a part of their post-war program of reconstruction and social security.

The principle of family allowances is not new in Canada. It has been recognized in dependents' allowances in the armed services, and, earlier, in mothers' allowances, relief payments and workmen's compensation. Income tax reductions for dependent children have been allowed to persons within the taxpaying bracket. At the present time less than half the 3,500,000 children of Canada are receiving benefit from these reductions. The Act extends benefits similar to those enjoyed by persons within the income tax category to two additional groups: those whose incomes are so low they receive less than the full income tax reduction, and those who are under the present taxable level of $1200 a year.

A considerable section of the wage-earning population falls within these two groups. According to the census figures for 1941 the incomes of 57.1 per cent of the wage-earning population outside agriculture came below $1200 a year. One-third of the total urban heads of families earned less than $999; another third earned $1000 to $1499. It might be well to recall here that, in 1939, the Welfare Council of Toronto estimated $28.35 weekly, or $1474.20[2] a year, to be the minimum required in the Toronto area to maintain a family of five in health and self-respect, and then only with the most careful planning, If this figure is taken as a rough yard-stick, it is obvious that family allowances will be a godsend to these two groups.

Nurses, of course, are well aware of the importance of nutrition in relation to the needs of growing children. Like social workers, they have seen their skilled services go down to defeat before the finality of income so limited it could not be stretched to cover the barest minimum of nourishing food. An examination of family income, with and without the addition of family allowances, shows the effect the allowances can have on family standards of diet.

Under the Act, the allowances vary in amount with the age of the children in the family. They increase as the children grow older and the expense of maintenance increases, ranging from a minimum of $5 a month for a child under six, to $8 for a child thirteen and over. Six to nine-year-olds get $6 a month and ten to twelve-year-olds, $7 a month. On the assumption that some of the clothing and equipment purchased for older children can be used for the younger, the allowance is decreased for children after the fourth. These gradations add enormously to the administrative complications but they are an attempt to ensure equitable treatment for all.

A couple with three children age 2, 11 and 13 years, whom we will call the Jones family, would thus receive a family allowance of $20 a month or $240 a year. This amount would bring their annual income of, say, $950 up to $1190, or to put it another way, increase the family income from $190

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2 In terms of 1944 prices, the revised Report estimates that $35.85 ($1864.20 a year) is needed to cover the same budget.

per person per year to $238 per person. This may mean the difference between actual want and at least a minimum standard of existence. For example, a study of income and expenditure of urban wage-earners' families in Canada, 1937-38, indicated that families with annual incomes under $199 per person showed deficiency in *all* nutritive requirements. Thus with the addition of the family allowance, the Jones family would be brought out of this category into the $200-299 a year grouping. According to the findings of this study, they will now have a sufficient supply of calories but will still be deficient in other respects.

Dietary studies have established the fact that food consumption per person falls as the family increases in size. This is particularly true of the protective foods such as butter, milk, eggs, cheese and vegetables, which tend to be replaced by bread and potatoes. Family allowances should do much to stay this trend in Canada, even without the very desirable reinforcement of increased public education on nutrition.

There is, as yet, little information in Canada on agriculture income in relation to family size. It would be dangerous to assume that farm homes are less in need of supplementary diets than their city counterparts. The types of home-grown produce available on the farm depend a good deal on climatic area — as well as on dietetic knowledge. Bread and potatoes too often occupy a disproportionate place on the farm menu. The import of fresh fruit and vegetables to the local market from milder areas is necessary at certain seasons on the prairies and in the northern districts of other provinces.

An increasing knowledge of nutrition and more accurate vital and social statistics have shown a lot of unswept corners in our national housekeeping and revealed some grim facts about the health and welfare of large sections of the population. The effect of dietary deficiency on the health, vitality and rate of growth of children, and on their ability to learn, has been amply demonstrated, here and abroad. Even so, we have taken only the first faltering steps in studying nutrition in relation to the total budget of different income levels of the population. One direct effect of family allowances may be the stimulation of community groups to conduct surveys similar to that of the Toronto Welfare Council, in urban centres, small towns and representative rural areas.

More food, and more wholesome food, are by no means the only needs of the Jones family. They may be sacrificing other vital wants to an adequate menu. In particular, medical and dental requirements are apt to be neglected, or postponed until a critical stage is reached, and the cost to the family and the community is considerably higher than if preventive care or early treatment had been given. In point of fact, the average parent cannot afford to purchase adequate health services for his family. The health insurance proposals under consideration for the past two years recognize the limitations of the family budget in this respect and would provide free health and medical care for all children under 16. Until health insurance comes into effect, family allowances will help to pay for medical attention, visiting nursing and other services of the kind.

Furthermore, shoes and warm clothing are an ever-present expense where there are children. Fuel may be short, another room may be needed, or a proper mattress for straight growth. An endless variety of needs come under the simple heading of "food, clothing and shelter". The only general terms in which they can be expressed is money. And the only persons who know these needs of particular children are the parents. Administrative experience in dispensing relief, mothers' allowances and, during the war, dependents' allowances indicates misuse of funds in a very small percentage of cases. Furthermore, provision is made in the Act to take the allowance away from parents who are

incapable or unwilling to spend it for the betterment of their families, and to place it under the control of some other person or agency.

It is true that family allowances alone will not bring social security. But they are a firm foundation stone. They are one more step forward in the history of child protection. It seems a far cry to the era of Dickens when schools, workhouses, prisons, and factories bore a dismal similarity, and health and nutrition were words of an as yet unknown language. The general level of living has risen immeasurably since then. Nevertheless, progress since those stark days has been in great and little steps as groups here and there awakened to duties and obligations, and made the community increasingly aware of its larger responsibilities. Each step forward has been an innovation and a struggle in progress. Family allowances is one of those steps.

Management and the Promotion of Industrial Health Services

R. M. P. Hamilton

"Management" is a very general term, and it should be stated that "good management" regard their responsibilities as an obligation-in-trust, requiring them to co-ordinate the bona fide needs of their source of financial support, whether this source be the shareholders of a commercial company, or taxpayers of a country, with their chief means of producing — which is their employee-staff.

Management, from an impersonal viewpoint, is made up of innumerable components, the important ones being, in so far as they affect industrial health service, three main influences or forces, viz:

1. The natural interest of the normal employer in the well-being of his employees.

2. The growing realization of even absentee directors that it pays dividends to keep employees healthy.

3. Applied public opinion, which is perhaps an inadequate but still a practical way of expressing the benefits, authority, and leadership derived from, and exerted by, such bodies as the public departments of health, and the employees themselves.

An industrial health service is a key industrial relation factor linking management with employees. Mutual confidence is the lubricant which makes this link between management and staff work well, or badly, depending on the degree of confidence present. Medical people will realize that "mutual confidence" is a two-way affair.

Functional forces affecting medical services: Even though management's medical knowledge may be limited to an idea as to when to use "aspirin", the chances are they can understand the problems of the medical services. If you want their help you should keep them posted and, objectively speaking, in your confidence. The strongest force for improving medical service comes from the average management's own interest in the welfare of their employees. Wanting to put the case in simple, practical language, as a parallel to carrying out the desires of a medical service, we went to our safety officer, and director of re-

search, from whom we got this fundamental answer to the question from a functional standpoint:

Our analyses show the components of an industrial health service to be: Interest by the employer in employee well-being; business recognition that industrial health service pays a commercial return; public opinion provided by the department of health. The question is, how can these be resolved into one force? The answer is, these forces, like other industrial relation problems, combine in the overall objective — "Prevention of Waste."

Prevention of Waste

You wonder why we took so long to build up this philosophy of "Prevention of Waste". The reason is illustrated in the two main principles which guide every activity in successful industrial health service:

1. The first principle is indicated by the assistance obtained in defining the basic objectives of a health service. The first source of information, advice, or guidance is the department of public health. The second source is the industrial doctor immediately concerned with the industry in question. If there is no such doctor, one should be contacted who is acceptable to the department of public health, preferably recommended by them. The third source of assistance in carrying out the medical service is represented by the engineering department of the industry, which must be called in on such matters as ventilation, illumination, sanitary facilities, safety facilities, etc. (Later we will touch on other departments which are definite factors in facilitating a medical service, particularly in the large industries, but for the moment the engineering group will serve to illustrate them all.)

In industrial health work, problems will occur which cannot, or shoud not be solved alone. A successful health worker will recognize the necessity of calling in complementary talent, and the good industrial health worker will be proud of the frequency with which he taps other assistance rather than attempting to work miracles alone, (for example, consider toxic dust elimination, lighting, etc.).

2. The second principle is illustrated by the simple philosophy of the phrase "Prevention of Waste". It seems to me that the main difference between a laborer and a professional person is that the latter usually follows an understandable philosophy. To guide one's self steadily amongst the intricacies of any job worth doing, one should be able to fit one's objectives into some simple overriding philosophy, such as the "Prevention of Waste". When you think of it, personnel work, safety work, medical work, nutrition service, all come under the same heading as does the business man's reason for watching his costs. This watchfulness on the part of management can be made an asset to a medical service if both are governed by the principle of "Prevention of Waste".

Co-operation with Allied Departments

Although, so far, we have only referred to an engineering department as an essential aid to health service, it is obvious to anyone who considers the question that the best industrial health services in the world will be wasteful of time and money if they do not have adequate support from the *other agencies of management.* Included in direct agencies of management, along with the medical and engineering departments, are safety, personnel, production, inspection, research, sales, accounting, purchasing, etc.

The medical service will, or should, rank equal to any of these other departments, but usually has no jurisdiction over them. For this it is dependent upon

the support of top management. Top management is not going to put up with a daily series of complaints or requests for support from any department, even such an important one as the medical service. Rather than depend on the sympathetic support of top management, which would be lost if too often required in detail, it is, therefore, up to the medical service to cultivate the respect and the interested regard of the other departments, without which a medical service will fail.

In discussing what amounts to the working co-operation between departments, we have not yet mentioned the plant Union, or the ordinary employee. In mentioning them now, it is unnecessary, one hopes, to stress the fundamental necessity of acquiring and maintaining their respect. If this employee-respect is not maintained it is obvious that the employees will not use the medical service and the medical service is, therefore, useless to the management or anyone else.

"Co-operation" is an overworked word, but if really put into practice it could cure all our industrial ills, whether physical or economic. The troubles occur when one of the parties who should co-operate expects the other fellow to do all the co-operating, and declines to meet him half-way because to do so would not suit his own ideas of the moment.

Functionally speaking, all organizations have the same problems. In the broad sense, the industry with a dozen employees, whose "medical department" is somebody who had first aid training as a child, has the same fundamental problems as the 25,000-man industry. The differences between the big and little industry are two: Big industry tends to suffer from the difficulties of maintaining personal contact, and no good human relationships can be maintained for long on a purely mechanical or statistical basis. Small industry, however, cannot afford the specialized facilities which the same *percentage expenditure* of time or money provides for big industry. These two factors more or less balance each other out, and one doubts very much if the industrial health problems in a big industry are any bigger or more easily soluble than those of a small industry.

Working with the nutritionists of a large industry to improve the meals in their cafeteria, a health service may find itself temporarily stopped by the comptroller. He will insist on the purchase of low-grade meat in order to reduce an apparent but immediate loss to the company through more costly food. It may be just as difficult, and take just as much applied patience and diplomacy on the part of the large company medical service, to obtain relief from the accounting dictum, as would obtain in the case of a fifty-man industry where the part-time industrial nurse may need to enlist aid to stop the local "greasy-spoon" from serving countless weird concoctions.

It is suggested, therefore, that there is little use considering one's own job unusually difficult. A large part of any professional success depends upon the ability to master the circumstances and personal equations which tend to retard professional progress.

The problem boils down to selling your knowledge or your ideas. The first essential in salesmanship is to create confidence. It should be remembered that confidence is a mutual affair, and to obtain the management's confidence, it is necessary to give them the confidence of the medical or other department desiring this close relationship.

Industrial Medical "Selling" has Four Phases

1. "Selling" the management boils down to demonstrating that the employee and, therefore, the company, get adequate return for money spent on employee health. The general method we, as management, use to convince our superiors is to show that our medical service costs under one half of one per

cent of our otherwise fixed costs. This is in an industry with explosive hazard and some toxic conditions in addition to ordinary accident problems. The directors, knowing that it costs us between twenty-five and fifty dollars to hire an employee, and between fifty and one hundred dollars to train him (depending on the times and work requirements) appreciate the value received from medical expenditures. Social security taxes are mounting by leaps and bounds and every business man know the first line of defence is "medical service".

2. "Selling" the other departments on the value of your service's requirements to them is sometimes slow. However, absenteeism costs the employer more than the employee by 50 per cent. Also 80 per cent of the visits to our medical department are due to non-occupational troubles and supervision of health is the key to prevention of this waste.

3. "Selling" the worker on the value of medical service to them is usually easy, (e.g., lost time due to illness is largely preventable—it averages fifteen times that due to accident and amounts to nine days per year per worker).

4. "Selling" the public on the value — to them — is usually done through the company. In the last hundred years industrial workers increased from 12 per cent to 29 per cent while agricultural workers decreased from 72 per cent to 21 per cent of the people at work. The increasing importance of good industrial health to the State is, therefore, obvious.

Management Problems of Interest to the Medical Service

Costs come high in any management docket, since no industry can operate long at a loss. Industry has, generally speaking, become accustomed to a cost of up to one dollar per month per employee for industrial medical service. Employees average ten to twelve calls per year at the medical department of an industrial service.

In meeting the management's need for controlling costs, the medical service will always find three things: Once they have earned a reputation for cost-consciousness, the management will increase the departmental freedom; most health objectives can be obtained at relatively low dollar cost, provided sufficient thought is spent on the proper means of obtaining the objective; once the worker is "sold" on health consciousness from a practical medical viewpoint, the worker contribution to industrial health will grow quickly by such obvious means as: (a) personal attention to sanitation, food, rest, etc.; (b) obedience to medical suggestions such as attention to specific diets, transfer from harmful occupations, etc.; (c) willingness to spend their own money on medical services such as hospitalization, which industry cannot supply.

The handling of labor turnover, absenteeism, training, alertness, job evaluation and many similar management problems can all be aided by a good industrial health service. The method of handling the management's problems from the viewpoint of industrial health is sound planning by the medical department. Policies and procedures should be studied if available in writing, and sought out and clarified if not.

Elements of Industrial Medical Service from Management Viewpoint

Assume that we are in an average-sized industry with the usual problems including a reasonably health-conscious management of normal intelligence:

(a) The medical service will be expected by the management to provide: (1) Pre-employment examination for guidance to the employer in worker placement, in accordance with plant *Policy and Procedure*. (2) First aid care and compensation data. (3) Prevention of spread of communicable disease. (4) Preparation of rudimentary statistics as to lost time due to compensable acci-

dents as distinct from non-occupational illness. (5) Advice to management of any important plant causes of occupational illness and means for controlling them. (6) Advice to employees who become ill while at work — up to the point of seeing their family physician. (7) Supervision of sanitary conditions throughout the plant.

(b) Additional accomplishments, possible with an aggressive medical service co-operating with other departments under a sympathetic management, include: (1) Advice as to workers' clothing and working conditions from the health standpoint; for example, aid in getting necessary eyeglasses, corrective shoes, and provision of adequate light on work. (2) Education of the workers in co-operation with nutritionists towards better feeding both at work and at home. Many poor workers *are* poor workers because they are underfed or badly fed. (3) Co-operation with public health advancement measures such as tuberculosis picture surveys. (4) Co-operation with the safety department in eliminating industrial accidents and through periodic medical examinations, eliminating sick people from work. Most accidents occur to tired or sick people. (5) Co-operation with production and engineering departments in eliminating harmful working conditions; for example, much of our dermatitis problem was eliminated by provisions of adequate dust collection and lighting. (6) Co-operation with wage-study departments in evaluating jobs, such as analyzing and comparing physical or nervous stresses on various jobs. (7) Co-operation with personnel and operating departments in getting and keeping healthy and satisfied employees. Quiet advice to these departments enables them to understand, place properly, and look after employees having special conditions of health or nervous strain. (8) Acquire practically valuable statistics on a variety of medical problems being studied by public health officials. (9) Carry out specific occupational and industrial medical researches. (10) Visit absent or known-to-be-sick employees for two purposes, viz: (a) to advise the company as to probable length of absence; (b) to advise the employee as to how to get necessary medical care from his personal physician, hospital, or elsewhere if such care is needed.

(c) Ten Commandments: or the things which management expects medical service to *avoid*: (1) Any act or practice unfair to any employee. (2) Participation in the inevitable plant politics. (3) Activities in union politics. (4) Sign of favoritism to individual patients. (5) Sign of disinterestedness in an employee's real or fancied illness. (6) Participation in disciplinary measures. When necessary, these must be taken by the proper department, which is never the medical department. (7) Lack of frankness in reporting objectively on any case of sickness or accident to the management, whose duty it is to keep confidence. (8) Sign of taking sides in either a company-employee or an inter-departmental dispute. (9) Lack of co-operation with public health officials. (10) Personal act which would detract from the employees' friendly respect for the company nurse or doctor.

Preview

With maternal mortality still a serious public health problem in Canada, the discussion of puerperal care and some of the complications which may occur becomes of immediate interest and importance. Dr. William J. Stevens has shown us how vital good nursing care is in the prevention of untoward complications. An important factor in preparation for the delivery is the adequacy of the prenatal care that is given. Kate McIlraith has outlined the nurse's role in this for us, stressing her value as a teacher. To round out the picture, Frieda Allum describes the physical set-up and classes held in a prenatal clinic.

A Twenty-five Year Retrospect of Infant Feeding

ALTON GOLDBLOOM, M.D.

The apparently simple present-day methods of feeding infants stand out in sharp contrast to the methods practised and the beliefs held a generation or so ago. The reasons why we do or do not do certain things, why we do or do not give certain foods, have changed materially together with our practices. It is by no means uninteresting, nor is it without some measure of indulgent amusement, to look back over the road which we have travelled this past quarter century to see where we have got to and where we have come from; perhaps, too, to try to see ahead a bit to where we are going.

A generation ago, infant feeding was regarded as a high and complex art and by no means a simple one. It required a year or two of study and practice to learn well. One studied pediatrics particularly with a view to learning infant feeding. It was the key to a successful pediatric practice. I remember a distinguished pediatrist of the United States who had at the top of his letterhead the words "Practice Limited to Infant Feeding"; and he was a busy man. If you were a young and ambitious doctor and wanted to be a pediatrist, you chose the school of infant feeding which you thought was the most advanced, and you went there to learn the method. You went to Boston to learn "percentage feeding", while another went somewhere else to learn "caloric feeding". It was the *method* of feeding that was most important. What was behind the method was the desire on the part of all pediatrists of the day to try so to modify cow's milk by dilution and by the addition of sugar, etc., as to make it resemble human milk in its composition; the reason being, of course, that if you could produce a reasonable facsimile of human milk, you would then have no trouble in feeding infants. All the efforts of those interested in the subject were directed towards producing an imitation of human milk. Today our aim is to provide an infant with adequate food on which it can thrive, without regard to the manner in which it may differ from human milk.

The appalling mortality of artificially fed infants in those days, and the manifest failure of all the divergent methods of feeding, made it necessary to have always on hand a fairly large supply of human milk in hospital feeding and, in homes where they could be afforded, wet-nurses for those infants who were very ill. New York and other large cities had wet-nurse directories, some maintained privately, like employment agencies, others by public charity organizations. Hospitals for children often kept as many as half-a-dozen wet-nurses, their infants admitted as "feeding cases" to the "feeding ward" as it was called; the wet-nurses were assigned to do light work and to pump or strip their breasts several times a day. This was thought to be better than the method of supplying district nurses to collect breast-milk from mothers who lived at home, nursed their babies, and sold the excess to the hospital at from four to six cents an ounce. The method was highly developed in Boston where at the Floating Hospital the "milk maids" would meet the boat when it docked in the late afternoon, each heavily-laden with the day's takings; bottles upon bottles of milk gathered from dozens of nursing mothers in the district. The trouble was that these mothers, who were selling their precious milk at a price for the sake of saving the lives of poor sick children in the hospital, were not above adulterating this milk, either by the old-fashioned method of adding water to

it, or by the simple expedient of mixing it with cow's milk. These frauds were fortunately detectable by simple methods. The wet-nurse in the hospital had no reason for practising such frauds, because she had her keep, light work and a home for her infant; moreover, she stripped or pumped her breasts under supervision. But she was a nuisance; she felt indispensable, as indeed she often was, and acted accordingly. Yet it was a great comfort to the attending physician to know that there were five or six quarts of breast-milk always on ice for use for our more difficult feeding problems. Indeed, many an infant was tided over a most critical period with human milk, when other milk would have failed.

The feeding of all infants in the hospital was directed by the head physician of the ward. No one else dared prescribe or change a formula. The interne merely observed with rapt attention and interest how this clever and omniscient man went about on his rounds changing the formulas according to his judgment. His judgment was based upon the weight, on the presence and nature of vomiting, and on the character of the stools; the last being by far the most important. A distinguished lady pediatrist, then an interne, used to call them "stool rounds". One might call them fecal fascination, or coprophyllic fetishism, or divination by stool. The professor purported to know, by examining the stool of each baby, what was wrong with him and how the food should be changed. And this was a ritual! The stool of each child had to be saved for rounds. They were done up neatly in brown paper folders and "filed" alphabetically. It was the duty of the junior interne to have charge at rounds — right after breakfast — of the basin containing the stool filing system. Of course, he could not stand too close to the professor and his followers; he was obliged to stand at a distance. When the professor approached the bed of an infant, the resident would call out the infant's name; the junior interne would look through his file, get out the desired folder, open it, approach the professor and from his breast pocket respectfully withdraw and present a wooden tongue depressor. The professor would then examine the stool, far more carefully than he ever examined a baby. He would comment on it, smear it back and forth with the spatula, smell it, and often deliver a short lecture on its characteristics. How we would marvel when the professor guessed, from the appearance of the stool, what food the baby was getting. "Dextri-Maltose" he would say. Some one would look at the chart, and Dextri-Maltose it was! "Protein milk" he would say — again he was right. A great man indeed! Then would come the great moment when the formula was changed: "Add 1/4 per cent of fat, take out 1/2 per cent of sugar, and split the proteins". The orders were carefully noted, and it was the duty of the junior interne to figure out the formula from a prescription that went something like this: "2 — 6.50 — 1.50 — 30 x 7" which meant that a mixture was to be ordered that would contain 2 per cent of fat, 6.5 per cent of sugar (which was always lactose unless otherwise specified) and 1.5 per cent of protein. There was to be 30 oz. of this, and it was to be divided into seven feedings. The sugar was always lactose, because that was the sugar present in human milk. We often smiled indulgently when we found a sick infant whose mother or whose doctor had been foolish enough to give him granulated sugar — no wonder the child was ill. The idea about sugar changed when the price of lactose went so high during the first world war that most people could not afford it. It was the late Dr. Howland, then professor of pediatrics at Johns Hopkins, who showed that cane sugar did just as well as any other sugar and was of course much cheaper.

Splitting the proteins was an under-

taking in these days, about as arduous as splitting an atom. It meant that the whey proteins and curd proteins were to be so arranged in the formula as to be of somewhat the same composition as they are found in human milk. When the order "split proteins" was given, it usually specified what percentage of casein and of lactalbumin it was to contain. The poor junior had to indulge in mathematical calisthenics in order to arrive at the proper mixture of cream or top milk and whey which would give the desired proportions. Until you caught on you wished Einstein were at your side to help you — eventually it became child's play. Protein was ordered "split" usually because the stool showed a bean curd, which represented a bit of milk curd that had escaped the action of the digestive juices, perhaps on account of its size. Yet its presence meant a fault in the infant's digestion and called for this drastic change.

Bean curd was also the reason for the almost universal use of barley-water for diluting the milk. Any cereal gruel mixed with milk prevented the formation of large tough curds; but barley, "patent barley", was the choice. It was a bit of heresy to use anything else, and "patent barley" sold for close to a dollar a pound, as did oven-browned ordinary wheat flour which, under a trade name, threatened to swamp the popularity of "patent barley". It resulted, therefore, in a great saving in money when, at the Babies Hospital in New York, the late and great Dr. L. Emmett Holt used ordinary wheat flour, either browned or natural, for making gruels for formulas. Dr. Holt was a scientific man, and he ordered the change only after he had demonstrated to the satisfaction of everyone that the gruel made from flour was as well digested as barley flour, and that it was equally effective in preventing bean curds from appearing in the stools. Boiled milk which also prevented bean curds was not as good for babies as raw milk, so that was not a way out of the difficulty.

Controversies raged over whether one should give high-fat or low-fat feedings. After all, if we were to follow the composition of human milk, we must feed 3 to 4 per cent of fat, but unfortunately this was rarely tolerated by many infants already debilitated by malnutrition. You were either a high-fat feeder or a low-fat feeder, and you either hated your opponent heartily or you had a sympathetic tolerance toward your poor misguided friend. There were feuds, and hot ones too, over whether one should use top-milk or whole milk in making up a formula. Top-milk formulas were difficult to understand; whey and curd formulas (split protein) were even more complicated. Neither were eminently successful, particularly with sick infants, and their popularity was short-lived.

There were a number of flagrant contradictions which were regularly practised in those days and which we, of the then younger generation, were quick to observe and query. The infant was unable to tolerate more than a certain percentage of fat, say 2, 3 or 4 per cent, depending upon whether you were a high-fat feeder or a low-fat feeder; but you always gave the baby three teaspoonfuls of cod liver oil, and often a teaspoonful of olive oil if he was constipated; yet this half ounce of pure 100 per cent fat never seemed to bother either the high-fat feeder or the low-fat feeder — this was medicine and didn't count. Another contradiction was the following: While all milk had to be diluted and modified for infants, sour milk could be given without dilution. In fact the Dutch method, which was said to have been a very old folk-method, consisted of sour milk to which, of all things, cane sugar was added, and it worked. This benefit was supposed to be due to the lactic-acid bacilli of the sour milk. In some vague way they made the food digestible by altering the intestinal bacteria. Whatever the reason,

whole lactic-acid milk with added sugar was a refuge when the standard methods and all other methods failed.

Milk had to be given raw. Not even pasteurization was good enough for formulas. Although Jacoby in the latter part of the last century was the first to advocate boiled milk for infants, and experience had many times demonstrated the greater tolerance of infants for boiled milk, the reasons for insisting on raw milk were that by boiling the milk the vitamins were destroyed and the enzymes were killed. What enzymes no one has ever yet learned, or of what importance they were to the infant; yet the enzymes were destroyed and milk must be given raw. This led to the development of "certified milk" — that is, milk from tested herds and produced under such conditions that the bacterial count was so low that it was safe to give to infants. This milk was twenty-five cents a quart, so that the benefits were for the rich only. The poor had to get along as best they could with pasteurized milk.

When I began to practise I was several times called to see children suffering from abdominal tuberculosis. The story was invariably the same; the child had been doing poorly — the doctor advised milk fresh from the cow. The people moved to the suburbs, and bought a cow whose milk was given fresh to the infant. Often such cows were tuberculous, and the unfortunate infants became infected. Such experiences were sufficient to convince a young pediatrist of the value of sterile milk for the feeding of infants.

The amount which the baby was allowed to have at a feeding was carefully controlled by the doctor. The rule was that a child might not have more at a feeding in ounces than his age in months plus one. Thus if he was three months old, he was allowed four ounces at a feeding and no more. The poor infant often was unaware of this rule, so when he cried he had colic. If you gave him more, there was danger of dilating his stomach. Why, infants on the breast who often gorged themselves with seven or eight ounces at a feeding at six or eight weeks didn't die horrible deaths, was quite beyond comprehension! Then the x-ray came along to show that the infant, whatever the capacity of his stomach, passed liquid food along into the duodenum rather quickly. Thus the rule was abandoned.

Our knowledge of vitamins in the second decade of this century was vague and limited. The one best understood was vitamin C, which was called "water-soluble C". All children received orange juice from a fairly early age, and knowledge of other sources of the vitamin was increasing. Tomato juice was found to be effective, but you could obtain this only by draining off the juice from a tin of canned tomatoes. Many mothers objected to this practice, because they abhorred the idea of giving their precious infants anything out of a can. It required some years to eradicate this prejudice.

In my early days of practice in Montreal, the late Dr. A. D. Blackader, who was always extremely generous to young men trained in pediatrics, sent me to see a child who was not thriving. The problem was not a difficult one, and was readily adjusted. The child was not ill, but was having a rather hard time with a formula that contained a lot of cream. I prescribed a simple formula of milk, sugar, and water, on which the child did quite well. I had ordered an ounce of orange juice to be given each morning. In a few days the mother complained that the infant did not tolerate the orange juice. I asked her to drain off the juice from a tin of tomatoes and give the child about two ounces of this each day. The poor mother was horrified at the idea of giving her baby anything out of a can, but my success in solving the feeding problem made it easy to convince her that this practice was both safe and beneficial. She

reported to me in a few days that the infant was doing nicely and that the tomato juice was being well tolerated.

For several months thereafter I was obliged to defend myself against the attacks of dowagers who had "never heard of such a thing". The story of myself and the tin of tomatoes kept coming back to me in many garbled forms. The final version of these apocrypha went something as follows: A baby was very ill and all the doctors had given it up. Nothing more could be done for it. Then up spoke one of the doctors and said "There is a young baby doctor in Montreal recently arrived from New York. Perhaps you might try him". I was accordingly called. I entered the house took one look at the dying baby and cried "Open a tin of tomatoes. Quick!" The tin of tomatoes was opened, the juice was given to the baby and the baby recovered!

Cod liver oil was given to prevent and cure rickets, but one was never sure whether it was something in the fish liver oil, or just any oil, which had the beneficial effect. Many schools held the view that any oil would do provided it contained phosphorus. In one hospital the clinic patients received as cod liver oil, a bottle of cotton seed oil to which was added a drop of oil of phosphorus. It was about in 1920 that it became to be fairly generally accepted that there was something in cod liver oil that many other oils did not possess, that had an effect in the prevention and cure of rickets. There soon followed the discovery of the effect of irradiation on rickets, then of the possibility of irradiating ergosterol; and finally the relationship between fish oils, irradiated substances, sunlight, etc., to the prevention and cure of rickets.

It gradually became evident that for an infant to do well, its food must be sterile, because many of its ills were due to bacterial diseases caused by raw milk. Boiled milk for infants had been advocated in the middle of the last century by Abraham Jacoby, in his time the leading authority on pediatrics in North America; but his views on this matter were never adopted in his lifetime. At the time of his death the controversy was still raging between the advocates of raw certified, "grade A" pasteurized, and boiled milk. The late Dr. Howland settled this question without great difficulty. The practice in his clinic was to give the necessary amount of food as boiled milk and cane sugar. It worked much better than raw milk formulas, and that was that. One of his pupils, the late W. McKim Marriott, was a man of great brilliance and resourcefulness. It was he who popularized the use of corn syrup as a cheap and useful sugar for the infant's formula. It was he, too, who was largely responsible for the wide use of evaporated milk. Evaporated milk with two parts of water and an ounce of corn syrup for every twenty ounces of total mixture, acidified with about a teaspoonful of lactic acid, made, he taught, an ideal food mixture for an infant, and did not require "changing of the formula". The lactic acid was added because he felt that part of the infant's digestive problems were due to the fact that cow's milk had the property of using up a good deal of the acid secretions of the stomach, so that when the acid was neutralized by the milk there was not enough secreted to permit normal digestion.

The addition of an acid to milk was a new idea. It was based upon the knowledge that infants could tolerate undiluted sour milk better than they did raw or pasteurized milk. This was for many years attributed to the lactic acid bacilli, until some bright mind wondered if the acid itself might not have something to do with it. Accordingly milk was acidified with lactic acid alone to the same degree that it usually becomes acidified through fermentation. This worked. Then others wondered if other acids worked in the same way, which indeed they did. The medical litera-

ture of the day was flooded with articles on the acidification of milk with different acids: citric acid, vinegar, hydrochloric acid, lemon and orange juices all called forth contributions to medical journals. In this period we learned that boiled milk was better than raw milk, that sour milk was as well tolerated as any milk, that evaporated milk was safe, chiefly because it was sterile; and that any sugar could be added to the formula, provided sufficient was given, and that the cheapest sugar was therefore the best.

Two other principles had gradually come to be understood in this period of progress toward simplicity. The one was that the infant must receive *enough* food: approximately two ounces of milk per pound of body weight for every twenty-four hours, with about an ounce of any sugar for every twenty ounces of the mixture, and water sufficient to make the total fluid intake three ounces per pound of body weight per day, more or less. This means very simply that an infant requires two-thirds boiled milk and one-third boiled water; or if evaporated milk is used, it is one-third evaporated milk and two-thirds boiled water, with sugars as already indicated. The whole divided into the number of feedings that the child takes, usually five, occasionally only four or even three.

The other principle was that the vitamins, particularly D and C, must be provided in adequate amounts from a very early age — a few days really — and throughout the first two years of life. From whatever source, an amount of oil must be given which will provide the infant each day with about 1000 units of vitamin D and sufficient fruit juice to yield between 30 and 50 mg. of vitamin C. This means an ounce or two of orange juice, or two or three ounces of tomato juice, or the pure vitamin in the doses mentioned. With these three principles always in mind—sterility, adequacy, and vitamins — the methods used in attaining these ends are of no importance. The goal is important; the manner of arriving at it is of less significance.

Present trends in infant feeding are all towards simplicity. Formulas which used to be changed by the doctor about once a week are now hardly changed at all. Spoon feeding with semi-solids, once withheld until the second half of the first year, are now given as early as six or eight weeks, rarely later than three months, and the variety of foods offered is limited only by the ingenuity and daring of the physician. These are steps in the right direction, and they are in the main responsible for the increasingly diminishing death rate among young infants, and for the generally improved nutritional state of artificially-fed infants virtually everywhere in the civilized world.

We have come a long way from the empiricism of a generation ago, and we are approaching the scientific attitude of inquiring into the reason for all that we do in infant feeding. We have ironed out most of our difficulties, and we have finally relegated the whole subject of infant feeding to its proper place in pediatrics. We are left with the never-ending task of studying and attempting to understand and, when possible, to cure the manifold and complex diseases of infancy and childhood. From baby-feeders we are gradually becoming physicians for children — or pediatrists.

Preview

Periodically we hear a suggestion that there is such a person as a "born nurse". Whether there is or not, there are definite characteristics which the *ideal* nurse should have. L. Evelyn Horton has put down her ideas for us of what these ideal characteristics include. Perhaps you would like to add others after you read her article in the May issue.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Teaching Microbiology

BLANCHE McPHEDRAN

A novel situation always creates interest. In introducing a course of Microbiology, the instructor has this advantage as very few students have had any instruction in this subject. Microbiology is one of the basic sciences of the preliminary curriculum. It is basic in that it provides a suitable, scientific foundation upon which many nursing principles are established. A knowledge of microbes, including their life activities and method of transmission, gives to the details of aseptic technique an interpretation of increased significance.

A suitable course of microbiology for nurses should place the emphasis upon the pathogenic aspects of organisms studied. Some time must be devoted to an evaluation of the beneficial effects in industry and public health of certain unicellular plants and animals.

Interest may be augmented at the beginning of the course by taking cultures from the students' hands, pens, uniform, or from such articles as door knobs and light switches. In twenty-four hours a blood agar or beef broth medium is rich with bacterial colonies. These same cultures may be used in a subsequent lecture to demonstrate shapes and arrangements of organisms.

If nurses are to protect themselves and teach hygienic principles to others, they should understand how organisms are transferred, how they enter and leave the body, as well as the mechanisms by which the body protects itself. In a community health program, no nurse would be considered adequately qualified unless she had a thorough knowledge of vaccines and sera; their preparation, indications for administration, time interval and quantity of each dose.

From the foregoing aims, it is evident that nurses are not being prepared as science specialists. This fact may be forgotten by the instructor in her eagerness to secure perfection of technical details in the practical aspects of the work. A break in technique would constitute a real hazard if students are permitted to handle such organisms as streptococcus hemolyticus, bacillus tuberculosis or other equally virulent specimens.

In no subject may the compatibility of theory with practice be better demonstrated than in microbiology. At least one-half of the total number of hours should be spent on practical work, and where possible the closest correlation between theory and practice should exist. For example, a period subsequent to a lecture on the history of the subject would be a judicious time to demonstrate the mechanism of the microscope and provide practice in its use. Or again, following a lecture in disinfection, the students should experiment with common mechanical and chemical methods.

A direct application of these principles may be secured by a visit to an isolation unit or operating room.

Adequate equipment is of prime importance for a successful course in microbiology. The students' laboratory should include at least: 1. facilities for culturing bacteria; 2. microscopes; 3. common bacterial stains; 4. centrifuge. The hospital laboratory may supplement such articles of equipment as an incubator, water baths, autoclave, animal cages, suction pumps, anerobic jars, and pathological specimens.

Part of the course should be devoted to the collection of specimens. How to avoid contamination of specimen, collector or handler should be emphasized. This suggests a practice where students may take throat cultures, later preparing, staining and examining bacterial slides.

Where the length of the course permits, a very vivid way of teaching immunology is by animal inoculation. Another satisfactory method is to correlate this instruction with the students' health program.

Following the preparation of bacterial slides, the students should be given an opportunity to stain and examine the organisms, using the oil immersion lens of the microscope. For beginners, this is a rather slow procedure, so that the instructor may wish to supplement this experience in one or both of the following ways: Most textbooks abound with authentic colour reproductions of organisms. Used with a projector, these prints are an effective way of demonstrating important points. Another time-saving device is the micro projector. This equipment attached to a microscope makes possible the projection of the actual bacterial forms, very much enlarged, on to a screen. This is a particularly suitable method, as it gives the instructor an opportunity to point out salient features which she can never be sure the student actually sees.

Correlation between the pathogen and the disease it produces is effective when the students see the clinical features. "Streptococcus Scarletinae" may be a meaningless term until the bright red rash or strawberry tongue of the patient leaves an indelible imprint on the learner's memory. At the present time when viruses are, for practical purposes, still ultra-microscopic, they seem more realistic if the students can see a patient suffering from "Measles" or "Chickenpox". In lieu of the actual patient, a coloured plate from a textbook may be effectively employed.

The value of student participation can never be over estimated. In addition to laboratory practice, progress may be enhanced by utilizing facilities provided by the community. The fascination with which students watch milk being processed or water being purified, bespeaks the value, not only as a learning situation, but as a stimulus to interest in the field of public health.

The following is a resumé of a combined course of lectures in microbiology, hematology and pathology. The number of hours devoted to this course is thirty-two—sixteen to theory and sixteen to practice. Although it may appear as if each laboratory period is subsequent to the lecture of the same number, the sequence is indicated by the number appearing in parentheses after the laboratory practice number:

THEORY:	LABORATORY PRACTICE:
1. General introduction: aims, history.	1. (1) Microscope — mechanism; care; use. Principal laboratory equipment.
2. General study of microorganisms: fungi; protozoa; viruses; bacteria.	2. (2) Use of microscope: instruction and supervision in taking cultures.

3. General study of bacteria: distribution; growth; methods of study.

4. Classification of bacteria: identification of bacteria.

5. Useful bacteria: infection — resistance; virulence; portals of entrance and exit; mode of transfer and prevention.

6. Disinfection: mechanical; physical; chemical.

7. Immunity: introduction; antigens and antibodies; classification.

8. Immunity: vaccines and sera; preparations used; relation to health program.

9. 10. 11. Study of common pathogenic bacteria: appearance; growth requirements; staining; pathogenicity; prevention of disease. The more common virus and protozoan diseases.

12. Pathology: causes of death, other than bacteria; value of examination of specimens; nurse's role in collection of specimens.

13. Pathology: tissues; neoplasms, degenerative changes; congenital defects.

14. Blood: normal; calculating number of cells; classification of anemias.

15. Blood: sources of blood for examination; blood chemistry; blood culture; Wassermann and Widal reaction.

16. Inflammation: causes; phagocytosis; resolution; exudates.

3. (3.4) Study of cultures prepared in laboratory 2: preparation of slides; demonstration of staining; dark field illumination; sugar reactions.

4. (6) Demonstration of disinfection by: boiling; chemicals; surgical scrubbing; cultures made before and after each.

5. (3.4) Preparation of slides from cultures of laboratory 4: staining — Gram's and acid-fast methods; demonstration and explanation of agglutination and pneumococcic typing.

6. (6. 9. 19. 11) Examination with microscope of slides prepared in laboratory 5: lantern slides of common pathogens.

7. (6) Sterilization: central supply room; medical aseptic pantry.

8. (6) Pasteurization: community dairy visits.

9. (12. 13) Pathological specimens and slides of tissues.

10. (14.) Demonstration of hemoglobin estimation and complete blood cell counts; preparation of blood films.

11. (14. 16) Examination of slides exemplifying abnormal hematological conditions: anemia, leukemia, leucocytosis, leucopenia, eosinophilia, lymphocytosis.

12. Staining and examining blood films prepared in laboratory 10.

13. (15) Demonstration of blood typing and grouping: relation to blood bank.

14. (16) Process of resolution demonstrated by diagrams and slides; technique for taking and value of blood culture.

15. (14. 15) Demonstration and explanation of bleeding time; coagulation time; sedimentation rate; fragility test.

16. Demonstration by diagrams and models of common parasites: nematodes; cestodes.

After having taught a course in microbiology, most instructors woud agree that the following questions are worthy of consideration: 1. Should microbiology be taught as a separate subject? 2. Could it be integrated with other subjects such as medicine, surgery, hygiene, communicable diseases and so prevent duplication of instruction? 3. Would a brief introductory or elementary course given in the preliminary term avoid the difficulty, exhibited by beginning students, in comprehending technical information?

The foregoing outline, with suggestions, has been used by the writer. From experience, it has been found to be practical, to provide for student participation, and to be valuable using student achievement as an index for appraisal.

Another Flood

Have you ever seen a rampaging river in flood? Or have you been in the vicinity of an avalanche? There is nothing that mere human beings can do to stop either. Ever since the turn of the New Year the *Journal* has been experiencing a flood — a flood of new subscriptions. We would not want to stop it for anything but, like the avalanche, it was so unexpected that we were caught unawares. The hundreds, yes, literally hundreds upon hundreds of new subscribers wanted to read a particular issue and asked to have their *Journals* start with a certain month. We are sorry but there is no way we can secure more when our supply for any one month is exhausted. We can only hope that copies have been shared so that none has missed the articles desired. Perhaps we should consult a soothsayer or a numerologist to give us advice on how many copies to order! We jumped the order eight hundred from January to February, five hundred from February to March and, as this is being written, have no way of knowing just what we will have to order for April. Will the new subscribers forgive the late starts? We are trying hard to provide you with the best nursing journal you can secure, in as large quantities as we require. Sometimes you surprise us!

—M.E.K.

Health of Workers Matter of National Concern

The Health League of Canada's "plan for health education and medical supervision in Canadian plants appears to fill a real need throughout our industries", it was stated in a message sent to the Industrial Division of the League by Hon. Brooke Claxton, Minister of National Health and Welfare.

This plan — developed in co-operation with the Ontario Department of Health — advises industrialists (1) how to start and operate a medical program for workers; (2) how to improve eating habits of workers; (3) how to maintain health of workers with a practical educational campaign.

In his message, Mr. Claxton said the Industrial Division of his Department is actively interested in the promotion of health among Canadian industrial workers.

"The health of Canadian workers is a matter of national concern, not only now when our war supplies are so urgently needed, but during the peace and reconstruction period to which we all so anxiously look forward.

Your plan deserves every success in Canadian industry, and we shall watch its advancement with a great deal of interest. I hope that individual industries and the Health League will feel free to call upon us for advice and co-operation at any time in any matter related to industrial health. This Department's only purpose is to promote the health and welfare of the people of Canada".

In re-endorsing the plan, Hon. Humphrey Mitchell, Federal Minister of Labour, wrote that "it is obvious to me that great care and intelligence has been used in bringing to the front the facts which have to do in a vital way with the well-being of those who toil . . . I feel sure that your program, if adopted by our industries, will contribute in no small way to a more effective war effort".

Hon. C. D. Howe, Minister of Munitions and Supply, in another re-endorsation said that "the general adoption of this plan by industry will do much toward reducing absenteeism in industry caused by illness and, therefore, the plan is important to our wartime objective."

—*Health League of Canada*

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Toxemia of Pregnancy

MARGARET MCNEILL

At Prince County Hospital, Summerside, Prince Edward Island, not long ago, I was asked to special Mrs. M, a primipara, thirty-seven years of age, Roman Catholic and a farmer's wife. This primipara was seven and a half months pregnant and I understood from her physician that she had given him much cause for concern for several weeks.

The patient was vomiting frequently, pale, very drowsy and showed considerable edema about face and legs. She did not have a headache. The physician told me that before admission blood pressure was 171/123, but on admission to hospital, and at rest in bed, it dropped to 158/122. Her urine showed albumin XX with some granular casts. The red blood count was 3,910,000; white blood count, 6,300; hemoglobin 80 per cent. Evidently, I had a two-fold problem; a very sick primipara, and an unborn, living baby.

My instructions were to keep my patient exceptionally warm with woollen blankets and dry heat. Visitors were not allowed. Diet was fruit juices, milk, and plenty of hot lemonade. This produced free sweating. She was given repeated intravenouses of glucose and saline. Small doses of Phenobarbital were given for restlessness, supplemented by Heroin grs. 1/12 the first night.

In the first twenty-four hours the urinary output was ten ounces. As sweating was profuse and vomiting had ceased, the physician was satisfied to continue the same treatment. After ninety-six hours, the urinary output suddenly increased, and the patient seemed greatly improved; blood pressure dropped; all nervousness and stomach symptoms disappeared. Her improvement continued for ten days, when she showed signs and symptoms of impending disaster. At this time the urinary output was twelve ounces in twenty-four hours; albumin XXXX and blood pressure climbed to 174/110. Headache became a prominent feature with slight visual disturbances. My patient was now eight months pregnant. Since she did not respond to treatment a Cesarean section was done that evening.

Before going to the operating room special care was given to the preparation of the abdomen. It was scrubbed with green soap and water, carefully shaved, then cleansed with ether and alcohol, and sterile towels and binder were applied. The patient was catheterized. No sedation was given. The operation was without event, and she was delivered of a living six-pound healthy girl.

Mrs. M's convalescence was remarkably free from complications; urinary output was good; blood pressure settled down to within normal limits, and

all other symptoms of toxemia disappeared. She left the hospital on the fourteenth post-operative day.

The interesting sequel to this case is, briefly, as follows: The patient again became pregnant seven months later and was admitted to hospital in nine months as a full-term pregnancy, with very slight pains and no evidence of toxemia. The fact of an uncomplicated second pregnancy definitely established the diagnosis that it had been a case of true toxemia of pregnancy, and not a case of chronic nephritis with a breakdown due to the stress of pregnancy. Mrs. M. was prepared for any emergency, and the physician decided to give her a short test of labour. His instructions were to keep a careful watch for any radical change in her condition. On the afternoon of the day following her admission to hospital, the patient began to have definite signs of labour when, suddenly, she complained of severe generalized pain in her abdomen. Her physician was called and found her in marked shock. He made a diagnosis of a ruptured uterus. A laparotomy was done immediately. On opening the abdomen the uterus was found to be ruptured, and the baby's head only was protruding through the rent in the uterus. There was practically no blood in the peritoneal cavity. A dead baby was delivered. The uterus was closed and the operation was completed in the usual manner. The patient made an uninterrupted recovery.

In discussing the case, the physician pointed out the danger of a ruptured uterus in subsequent pregnancies following Cesarean section. The dictum "Once a Cesarean, always a Cesarean", is particularly true in a case where a section is done for toxemia of pregnancy. Due to the constitutional disturbances in toxemia of pregnancy tissue healing is of a poorer quality than in a healthy individual.

If Mrs. M again becomes pregnant she will run a considerable risk to her own life, and will undoubtedly be advised to have a section done at term and before the onset of labour.

Of Historical Interest

A little-known story of peculiar Canadian interest is attached to the life of Florence Nightingale.

In early life, Florence Nightingale was engaged to her first cousin, John Smithurst of Derbyshire, England. Marriage was forbidden by both families, probably on grounds of consanguinity. Mr. Smithurst eventually entered Holy Orders and went out to minister to the Indians at Fort Garry, later to be known as Winnipeg.

In 1851 the Reverend Mr. Smithurst returned to England. Whether he still hoped that a marriage was possible is mere conjecture, but it is significant that it was in this year that Miss Nightingale made a final decision to give her life to nursing. Miss Nightingale entered the Deaconess School at Kaiserswerth. Mr. Smithurst returned to Canada and became rector of the Anglican Church at Elora, Ontario. He died there, and lies buried in the old churchyard. The silver communion service still in possession of the church at Elora was a gift from Florence Nightingale in 1852.

—N. L. BURNETTE

Preview

Following up the discussion on industrial hygiene which appears this month, Mrs. Lois Grundy has prepared a detailed account of a program in action. The mushroom growth of the ship-building industry on the Pacific coast during the war years provided the opportunity for the development of a very broad plan for the supervision of the health of thousands of employees.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Far Be it From Me to Boast — But

SHEILA C. MACKAY

We are a progressive race, we Albertans — at least we like to think of ourselves as such — and sometimes we do something that would really seem to indicate that we are. Now, take for instance, the summer school for graduate nurses that has been held during the past two summers, under the auspices of the A.A.R.N. at the University of Alberta. We're proud of that summer school. As yet, it is the only one of its kind in the Dominion of Canada. And not only is it helping to meet, in some measure, the great need of the province for trained personnel in the public health and teaching and supervision fields, but also the needs of many of our nurses, who, because of lack of time or funds, have previously been unable to take this post-graduate work.

It includes the two courses — ward teaching and supervision, and public health nursing. Instruction is given over a period of ten weeks each summer and the successful completion of one such summer's work, in either field, qualifies the nurse for a certificate of attendance and standing. A student with university entrance qualifications will receive consideration for the credits obtained, should she wish to register in the Bachelor of Science degree course in the future, and all this for an amazingly small fee. The bulk of expenses attendant upon conducting the school is defrayed by the A.A.R.N. Even the necessary textbooks, as well as any amount of supplementary reading material, are supplied through the Association Library.

Thanks to these courses, forty-seven inspired women stepped from our campus on August 5, 1944 — twenty of them bravely resolved that student nurse training and hospital administration should henceforth be pursued upon a much higher plane; twenty-seven valiantly intent upon enticing the man on the street into fervently desiring good health, and all forty-seven staunchly determined to apply the scientific approach to every imaginable life situation, from learning to drive a car on muddy roads to convincing student nurses that anatomy and physiology *is* interesting.

In all seriousness though, the word "inspired" is used advisedly. Goodness knows how we looked, but we *felt* inspired, for our courses were so designed as to be eminently stimulating and thought-provoking and, withal, practical. They were made more so perhaps because many of our number had had several years of experience in their respective fields and had come to the University laden with unanswered problems — problems which, of course, we solved. In fact, any problem in either course that couldn't be thrashed to a solution in class (a theoretical solution,

at least) was unsolvable. Miss Nightingale herself — or even Houdini — would have been stuck by such a problem!

We naturally cannot give you the curriculum in its entirety, but there were a few highlights which we can't restrain ourselves from mentioning: our fifty-seven hour course in mental hygiene from Dr. Samuel Laycock of the University of Saskatchewan — our lectures in nutrition from Dr. Jennie Rowntree of the University of Washington (both of these subjects were taken jointly by the two sections) — our seminars in public health nursing — our panel discussions in nutrition — those lessons in materia medica that the T. & S. girls had to teach (they'll never forget them!) — the impromptu speeches that the P. H. Section nobly quavered through — the too-fleeting glimpses that we caught of Miss Kathleen Ellis, then Emergency Adviser of the C.N.A., and of Dr. Pett, Director of Nutrition Services of the Dominion Government.

Then there were our eighteen hours of study in Contemporary Nursing Problems (another joint subject) — hours, all too brief and too few, packed to capacity with analyses, discussion, and the occasional disagreement. We know now why professionalism rather than trade unionism is desirable for nurses, as well as innumerable other "whys and wherefores" of the nursing world. What is more, *we know our present day nursing leaders*. We know them because we were given an assignment, "Go find ten nursing leaders of today," we were told. "What have they done? What are they doing? What are they apt to do? And bring them in *alive* and *kicking!*" — or words to that effect. And we did as we were bidden with a mighty will. We ransacked files and drove librarians psychotic. We did everything but write to the Wartime Information Board. We venture to say that never before have so many illustrious ladies been dragged mistakenly from retirement and hurriedly thrust back again! But we learned something from that assignment. We not only learned who are our leaders and where they are leading us, but we stepped, for a brief moment, on to the heights where they are standing, saw the visions that they are seeing, and knew surely that the future of nursing is safe in their hands, for their dreams are good, and their will to accomplish burns strong and unquenchable.

We would like to tell you more of our summer school, of our picnics and how we learned to jujutsu, of our get-togethers, and how good the doughnuts were. Of our encounters with the Navy (whose quarters, believe it or not, all but surround the A.A.R.N. Library), and of how it whistled at us, glory be! and almost swept us out to sea every day. But space — and dignity — do not permit.

We can only sum up by saying that those who arranged and directed our activities did everything in their power to make our courses of vital and practical value to us. They made us work. They made us think. They played with us. And they sent us out with a solid groundwork of knowledge and a wealth of inspiration that we won't soon lose.

What more could possibly be desired? Nothing, *we* think.

Flash!

Calling all graduates from the McGill School for Graduate Nurses! Please take about five minutes to jot down your name and address and send it in time to have it reach the secretary-treasurer, Miss Rosemary Tansey, Montreal Convalescent Hospital, 3001 Kent Ave., Montreal, P. Q. by *May 15*.

Summer School for Graduate Nurses

MADELINE McCULLA

The School of Nursing of the University of Alberta, at the request of and under the auspices of the Alberta Association of Registered Nurses, has conducted a summer school for graduate nurses for the past two seasons. The project was financed by the Government Grant given to each province through the C.N.A.

During the summer of 1943 the School was under the direction of Miss Helen G. McArthur, M.A., then acting director of the School of Nursing. Special lecturers were Miss Rae Chittick, M.A., director of health education at the Normal School in Calgary; Dr. S. R. Laycock, professor of educational psychology, University of Saskatchewan. The instructional staff during both sessions included Miss Helen E. Penhale, M.A., of the teaching faculty of the Division of Study for Graduate Nurses, University of Western Ontario, who was responsible for the courses in ward teaching and supervision.

The summer of 1944 found some staff changes with the School under the direction of Miss Madeline L. McCulla, M.A., new acting director of the School of Nursing. The special lecturer at this session was Miss Jennie Rowntree, Ph. D., professor of home economics, University of Washington.

The course has fulfilled a very definite need during this wartime emergency by providing qualified graduates for many vital spots in the public health field, and instructresses and ward teachers for schools of nursing in the province.

Boosting Morale in the V.O.N.

CHRISTINE LIVINGSTON

The morale of Victorian Order nurses throughout Canada is high these days because of various progressive measures recently enacted on their behalf by the National Executive of the organization. These measures include the awarding of scholarships to assist nurses to take post-graduate training in public health nursing; the provision of an initial uniform allowance; and the establishment of a plan for retirement annuities.

The Victorian Order of Nurses, as other public health nursing organizations, has been endeavouring to maintain standards and policies in the face of a continuing shortage of adequately trained personnel. During the war years, the demands for the service have increased, new branches have been opened and in some localities the program has extended to a part-time service in industrial plants. A further expansion is expected in the post-war period, when the Victorian Order will be co-operating with official and voluntary agencies in future health programs for Canada.

To more adequately meet the present demands and to be prepared for future developments, the Victorian Order is endeavouring to increase the supply of well-qualified public health nurses by the awarding of scholarships. The amount of each scholarship offered by the National Office to nurses who have graduated

A welcome visitor.

from accredited schools of nursing is $500. The candidates agree to serve one year with the Order on the completion of their public health course. In addition to those provided for one year's post-graduate training, financial assistance is sometimes given to Victorian Order nurses for advanced study on a supervisory level. Although the scholarships are awarded nationally, regional recruitment is encouraged.

The second development deals with the question of a uniform allowance. It has been realized that the initial expense of purchasing uniforms has created some degree of difficulty to new nurses coming on the staff of the Victorian Order. Therefore, a recommendation was forwarded to the National Executive from the Advisory Committee on Nursing and from the conference of Victorian Order nurses held in January this year that the payment of an initial sum of $75 uniform allowance be made to nurses on appointment to the staff for at least one year. This recommendation was approved by the National Executive and became effective February 1, 1945. Although the arrangement is an experiment undertaken by the National Office, there is indication that, following the demonstration period, the project may be continued, as many of the branches have expressed their willingness to participate locally in the plan for uniform allowances.

The third measure is concerned with a plan for retirement annuities for nurses. For many years there has been hope that such a plan would be provided for Victorian Order nurses and now this hope has been realized. Largely through the personal generosity and effort of the national president, Mr. J. W. McConnell, a fund for retirement annuities has been established and it is expected that the plan will be in operation before the end of 1945. Although the details of the project are not yet complete, a government annuity plan under consideration provides for a threeway contribution, shared by the National Office, the local branch and the nurse.

A Post-Graduate Course in Psychiatric Nursing

CATHERINE LYNCH

The announcement that a post-graduate course in Psychiatric Nursing has been approved by McGill University opens up a new avenue for the preparation of nurses in a clinical specialty. That psychiatric nursing should have been selected is encouraging to those who are already bending their efforts in an endeavor to prepare nurses in this field.

Articles have appeared in *The Canadian Nurse* and the *American Journal of Nursing* setting forth the need for psychiatric experience in pediatric nursing, in orthopedic nursing, and in industrial nursing and asking that the means

for nurses to become qualified be made available. We have been brought face to face with the urgency for adequately prepared nurses in mental hospitals through the Survey made by the Canadian Nurses Association. The need cannot be overemphasized.

There is an abundance of clinical material in psychiatric departments of general hospitals and in mental hospitals. In order to use this to advantage we must prepare head nurses, teachers and administrators who in turn will plan teaching programs for affiliating and post-graduate students. The setting-up of a well-administered post-graduate course should not cause us to lose sight of the need for experience in the undergraduate course. This applies to psychiatric nursing just as it does to surgery, pediatrics and obstetrics. The student nurse, until she has been taught to understand behaviour in the person who is not ill, does not look objectively at the symptoms presented by the mentally ill patient. To understand the well person, to recognize symptoms in the ill person, and to learn to utilize varied approaches to different patients, should be included in the aims of the under-graduate course. The post-graduate student who has added to her basic course one year of satisfactory nursing experience, and has demonstrated aptitudes and abilities necessary in the field of psychiatric nursing will develop her understanding to the point where she is able to adapt effective nursing care for the patient whose behaviour limits him in the acceptance of this care. Miss Eva Moore has given us an excellent example of this in her description of the elderly patient with a cardiac condition whose concern for his son made it difficult to keep him in bed. The experienced nurse helped him solve his difficulty, making it possible for him to get the bed-rest his physical condition required.

This illustration brings up another point. The psychiatric nurse must have a thorough knowledge of the nursing of the various physical ills from which the patient may be suffering. Medical conditions occur just as they do among any group of people and they are cared for in the same way. Surgical conditions, although not appearing so frequently, call for good surgical nursing care.

In the December, 1944 *American Journal of Nursing*, the Committee on Post-Graduate Clinical Nursing Courses has with clarity classified, defined and described types of clinical courses. In the March issue of *The Canadian Nurse* Miss Lindeburgh wrote on "What Constitutes Post-Graduate Clinical Courses". She has set forth the principles of administration and this firm foundation gives strength to the aims of this new course which are:

1. To develop a broader understanding and greater skill in nursing mentally ill patients by becoming more proficient in the recognition of symptoms and the interpretation of behaviour.

2. To assist the nurse to acquire the knowledge and ability necessary to participate in a program for the prevention of mental illness and the promotion of mental health in the community.

3. To prepare this nurse specialist to administer a psychiatric nursing service and to assume supervisory responsibilities in relation to the care of patients and the development of the teaching program for student nurses.

The course will open with one month devoted to observation. This will include services selected for their clinical value, and time and opportunity to observe. The value of early recognition of the illness and seeking of medical assistance will be demonstrated as well as the methods used in bringing about recovery. The nurse will be guided in acquiring a good technique of observation. There will be supervised experience in the care of the various types of mentally ill patients, and practice in such

forms of therapy as shock, occupation and recreation. Beginning the second month, lectures will be given in McGill University and the School for Graduate Nurses, including Psychology, Sociology, Mental Hygiene and Child Psychology, Trends and Developments in Nursing, Public Health and Nursing, Psychiatry and Psychiatric Nursing. Correlation with progressive stages of clinical experience will be accomplished through conferences, clinics, demonstrations and special studies. During the last three months of the course an intensive clinical program is planned to provide supervised practice in Ward Administration, Supervision, and Teaching.

The facilities of the Allan Memorial Institute of Psychiatry of the Royal Victoria Hospital, the Verdun Protestant Hospital, an institution of 1500 beds, and other community agencies will be used for experience and teaching.

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Obituary

Christina M. Dick, for more than twenty-five years in charge of the nurses' home of the Johns Hopkins Hospital, died recently at the Johns Hopkins Hospital in Baltimore. Miss Dick was born in Brampton, Ontario. She graduated from the Johns Hopkins Hospital School of Nursing in 1899, and had a long and distinguished career.

Prior to the last position which she held for so many years, at various times she held the following positions at the Johns Hopkins Hospital: private duty nurse, head nurse, night superintendent, assistant superintendent of nurses, and instructor in the practice of nursing. In addition, she was superintendent of Rainbow Cottage, Cleveland, Ohio, from 1904 to 1905; superintendent of the Baltimore Eye and Ear Hospital from 1905 to 1910; and superintendent of Grace Hospital, New Haven, Connecticut, from 1912 to 1914.

Burial was in Brampton, Ontario. Miss Dick is survived by her sister, Miss Elizabeth Dick, who is also a graduate of the Johns Hopkins Hospital School of Nursing and appointed to that staff.

Regarding our Official Directory—Attention!

In our June issue the complete Official Directory will once again make its quarterly appearance. Will all Associations, which have not already done so, please send us their lists of new officers at once. (Don't forget to include the Secretary's address.) Remember we cannot keep your announcements up-to-date unless you co-operate by forwarding us the latest information as soon as it is available. In spite of careful checking on our part, mistakes do creep in. So check your announcement as it now appears in the March issue and let us have your corrections and changes.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

National Conference of Women

In all parts of Canada women have been preparing themselves for the post-war rehabilitation era. On Thursday, February 1, under the aegis of the National Council of Women, the first conference of Canadian Women's National Organizations met to contribute to the discussions and findings. Fifty-three organizations were represented. H.R.H. Princess Alice sent a message of greeting, expressing her pleasure that so many affiliated groups had joined in an agenda which covered the whole field of the social and economic welfare of the country's present and future. She stressed that women "through the war, have found a very real place in the public and structural life of the community and nation", and expressed the hope that "women will have places in all the different departments being set up for relief, rehabilitation and reconstruction."

The Importance of the Home was the first item on the agenda and was led by Mrs. R. B. McElheran, Toronto, president of the Anglican Women's Auxiliaries and Mrs. Roger Self, president of the United Church Women's Missionary Societies. Attitudes to women and the home are changing with time, said Mrs. McElheran in speaking of "marriage—a full-time job". Modern practices tend to separate members of families, and she suggested that marriage should be considered a way of life, not a job. Neglect of religious training was blamed by the speaker for the disintegration of home life.

Partnership in Family Life was led by Mrs. Harvey Agnew. Employment and Social Security was led by Miss Margaret Hyndman, K.C. and Alderman Hilda Hesson of Winnipeg.

Single Women in Business and Professions was the subject for discussion at the afternoon session. Miss F. Munroe, president of the Canadian Nurses Association, outlined the organization of the Canadian Nurses Association and the present situation with regard to nursing and nurses. Miss Marion Lindeburgh, convener of the Postwar Planning Committee, outlined the work of her committee.

That there will be great opportunity for young women in the post-war era as home economists, dietitians and nutritionists was emphasized by Miss Mary Clarke.

The Household Help Problem, which has become exceedingly acute during the war, lies with the woman employer, maintained Mrs. Harvey Agnew. It is largely within her power to change present attitudes and solve the problem. Resolutions sent to the committee which will deal with these matters suggested that pressure be brought to bear on Dominion and Provincial Governments to implement at once a training program for household helpers; also that the national organizations undertake a campaign of education of women employers as to conditions of the house-worker.

Dr. Edna Guest spoke on the need for a national health program. Need for a physical fitness program was made clear in the great number of military service rejections.

Dr. Vibert Douglas, Dean of Women at Queen's University, stated that education is fundamental to citizenship. She believed that there should be greater uniformity of standards in the provinces, better salaries for teachers — "those in some places being iniquitous and none too good, at best". More emphasis on the spiritual development is essential, Dr. Douglas asserted, speaking of the Bible as a great treasure house of wisdom and literature, which should be taught. Better school trustees are something the electors can easily demand, and women can help obtain this end, she said.

A resolution stressed the necessity of recruiting and training adult leaders for 'teen age children, and another urged the establishment of nursery schools as an extension to the education system.

An amendment to the Housing Act, so that the municipalities, provincial and federal governments would co-operate in subsidizing housing for low-wage families, was approved.

Loss of so many young men in the war has presented a challenge to women of talent and ability to step in and fill the gap, and it is up to older women, at present leaders in government and community, to encourage these young women, said Senator Iva Fallis, speaking on Women in Public Life. She doubted whether women of Canada have in any large numbers made a determined effort to fit themselves for public life; women are accepted in business, in the professions, why have we not come to be regarded as necessary to public life!

Senator Cairine Wilson stressed the need for more women representatives on public boards and committees, as well as in Parliamentary life, and praised efforts of pioneer women who had agitated for reform. The cause of women representation, she said, "must be pressed without bitterness, without intolerance or impatience". It is weak and foolish for women in possession of full citizenship to go knocking at the back doors of governments asking for appointments was the statement made, by proxy, by Alderman Frances Henderson of Hamilton. Everything we do, or try to do, for society is superficial unless we increasingly gain positions in governments — local, provincial and federal.

Responsibilities of Citizenship was the subject of the discussion at one of the later sessions. Miss Joy Maines, president of the Canadian Association of Social Workers, spoke on juvenile delinquency as a problem for community action, and pointed out that there is too little emphasis on parental responsibility.

More complete co-ordination of all adult educational activities on a community level was suggested by Miss Elizabeth Long; also a nation-wide public library service — 54 per cent of Canadian population is without this service at present.

Demobilization of women from the services and industry was summed up by Squadron Officer Jean Davey, R.C.A.F. (W.D.). She suggested that people should not look upon women leaving the services as problems to be adjusted. They should remember that these women have had unusual and valuable experience, which will enable them to make a real contribution to the country — "Let them see you expect leadership and responsibility from them and you will get it."

Mrs. Donald A. McKenzie, of the Canadian Red Cross, spoke on the war brides, explaining the procedure of the Society in looking after these young women from the time they leave Britain until they are turned over to I.O.D.E. and church groups in Canada.

The conference ended with a panel discussion on National Unity. "Our boys are fighting together and dying together on the battlefields — it does not matter to what race they belong; they are Canadian, they are ours", said Madame P. W. Marchand, who for thirty-two years had headed the Federation des Femmes Française-Canadienne.

Mrs. Harold Lorie, head of the National Council of Jewish Women, spoke on behalf of the 165,000 Jews in Canada. She emphasized the fact that the Jewish people, with 1,647 enlistments and a great volume of war work done by the women, were "patriotic and loyal".

Mrs. B. Dyma, Winnipeg, told what the Ukranians have accomplished in the agricultural life of their adopted country. Forty-nine per cent of Ukranians in Canada are farmers, she said; there are over a thousand teachers and a considerable number of other professions.

The resolutions committee took over the task of preparing planks for future action. The Canadian Nurses Association submitted the following resolutions:

1. That the National Conference of Women endorse the request of the Canadian Nurses Association for representation on the Dominion Health Council;

2. Whereas the Canadian Nurses Association recognizes the place of subsidiary nursing groups and has demonstrated its interest by the setting of standards for the training of such workers; and whereas the Canadian Nurses Association is agreed that in order to ensure the safety and protection of the public, any program for the preparation of subsidiary nursing groups should not be implemented until Provincial Governments pass legislation for the licensing and control of subsidiary workers; therefore be it resolved that the Conference of Canadian Women's National Organizations here assembled endorse the policy of the Canadian Nurses Association, namely:

That preliminary to the establishing of training courses for subsidiary nursing groups, Provincial Governments pass legislation for the licensing and the control of such workers.

United States National Nursing Council for War Service

The United States National Nursing Council for War Service has for some time provided the Canadian Nurses Association with reports of the activities of the Council. We were very much interested in a recent report given by Miss Lucile Petry, Division of Nurse Education, United States Public Health Service, which contained an outline of the effects of the Nurse Cadet program on nursing education. These included:

1. Improvement in the quality of applicants throughout the country.

2. Improvement in educational programs because of having a little money to spend on libraries, laboratories and other institutional facilities.

3. Increasing interest on the part of colleges in nursing education.

4. Improvements in nurses' residences through allotments of Lanham Act funds to Bolton Act connected projects.

5. The tendency of the program to focus the school's attention on its budget.

6. More applicants have learned the characteristics of a good school of nursing.

7. The amount of service contributed by students has prevented a collapse of nursing service in hospitals. Although only 1,234 or 29 per cent of the non-Federal general hospitals have schools, those with schools handle 56 per cent of the patients. Student service in hospitals with schools average 60 per cent.

Nursing and Nursing Education in the Future: In newspapers and magazines, reference has been made to a proposed integrated hospital system which would be part of a plan to give all citizens equal opportunity for "the full benefits of good medical care."

This plan refers to an integrated hospital system with a base hospital serving as a centre of research and teaching. Each state would have at least one of these hospitals, some of which will have a medical school connection. In addition, there would be district hospitals, a little smaller, carrying all the major services and taking all but the most complicated cases. The district hospitals would receive as patients from the next

smaller units, the rural hospitals, the cases they are not equipped to care for. Still further removed would be the health centre, a combination of the local health officer's office, the public health nurse's office, dental clinic, etc. There would be an interchange of both personnel and patients in this integrated system of hospitals.

Nursing care would be given in all four types of hospital and health centre situations described above, in public health nursing agencies and in homes, by a combination of professional and vocational nurses.

In the educational system fewer and better basic schools for professional nurses would be needed. Most of these schools would use base hospitals for clinical fields and would be parts of universities. The district, rural and health centre situations would be used on an affiliation basis. All nurses would be prepared thoroughly in the preventive, social and mental hygiene aspects of nursing.

The basic professional curriculum leading to a baccalaureate degree would probably require four to five years. The service given by learners in all curricula would be only incidental, the experience being chosen entirely for its educational value.

There was referred to the National Nursing Planning Committee by the National Nursing Council the urgency of the need for definitions of "professional" and of "vocational" nursing and the preparation and functions of "professional nurses" and of "vocational nurses".

Use of Red Cross Volunteer Nurses' Aides in the Post-War Period: The following principles relative to the use of Red Cross Volunteer Nurses' Aides in the post-war period were given approval by the Council:

1. That there will be in peace time a place for Volunteer Nurses' Aides in hospitals and clinics and that such a place can best be filled by aides selected and trained by the Red Cross on the basis of substantially the same national standards as now prevail.

2. That hospitals should in peace time assist in the training of Red Cross Volunteer Nurses' Aides as an educational responsibility to the community for — in addition to filling a need in the hospitals and being prepared to serve in case of disaster or epidemic — these trained volunteers will be invaluable to interpret the hospitals to the community.

"U.S.S. Higbee"

For the first time in history the United States Navy has placed in commission a vessel named in honor of a Navy nurse. The ship was christened in honour of Canadian-born Lenah Sutcliffe Higbee, second superintendent of the U. S. Navy Nurse Corps (1911-1922), one of four women to receive the Navy Cross and the only woman to receive it during her life-time. A battle flag was presented to the *U. S. S. Higbee* by Miss Stella Goostray, chairman of the National Nursing Council for War Service in the United States. Mrs. Higbee was born in Chatham, New Brunswick, in 1874. She graduated from the New York Post-Graduate Hospital in 1899 and joined the Navy Nurse Corps in 1908. She retired from service in 1922 and died in 1941.

Mental Defectives

Sterilization of mental defectives should be given careful consideration, it was stated in the report of the Saskatchewan Health Services Survey Commission which was released recently.

"Much experience has been gained in this field during the last fifty years in America and Europe", the report said. "One should not be deterred by the fact that Nazi Germany has practised sterilization in a brutal and wholesale manner, but should study the results obtained in such countries as the Scandinavian countries, Switzerland, and some of the American States where sterilization has been practised humanely and cautiously with good results".

—*Health News Service.*

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Opportunities in Nursing Service

With the appearance of prospects of early peace, we sense a return of the apprehension concerning future, now become immediate, opportunities in nursing. Will there be work for all registered nurses in Canada? To help quiet your apprehension, the Committee on Postwar Planning is pleased to present this brief outline of the nursing service opportunities now existing in Canada and a forecast of requirements for the not-too-distant future. Though we be accused of uttering a platitude, we feel that during the war years a definite restlessness of spirit has taken possession of our people. A great many feel unsettled, dissatisfied with their present niche. Especially has this fever for change, for new things and new excitements infected "the younger set". Our young nurses belong to this "younger set", and like all others of their group they are loathe to "settle". They feel that there is so much to be done, so many opportunities awaiting the graduate, and their young minds are quite confused. This state of mind has resulted in an almost constant fluctuation of hospital general duty personnel — usually the first position open to the new graduate. Having just completed three years in hospital service she feels an urge to "do something beside bedside nursing" — something more exciting, something to her, more important. The tragedy of this situation lies not so much in the fact that these nurses are overlooking a most valuable period of their career — the period when their three years "learning" is about to be consolidated on a really skilled professional level — but in the fact that the patients, those for whose sake presumably they took up the nursing art, are frequently being left unattended in our hospital wards. Granting the importance and attraction of the other fields of nursing, the paramount need today is for more bedside nursing. The general hospitals need nurses in increasing numbers to care for patients with medical and surgical conditions. In the wake of the war, we find a much greater demand for nurses skilled in the care of orthopedic and psychiatric patients. Large numbers of nursing personnel proficient in these specialties are needed to assist in the rehabilitation of these patients.

We feel that we cannot stress too fully or too often the importance of bedside nursing in the total nursing picture. Can we as a professional group deny the too frequently heard accusation that nurses nowadays seem to be doing everything *but* nursing the patient?

We understand that the Department of Veterans Affairs is developing an extensive hospitalization plan which will require a large number of nurses for staff purposes. This opportunity to continue to nurse the wounded veteran may have a special appeal for the nursing sister who has had the privilege of sharing front-line experiences with the combatant.

With the ever-increasing popularity and spread of prepaid hospitalization plans comes an increase in demand for nursing services which in turn has creat-

ed a demand for nurses which is at present being unmet.

With the present and anticipated continued shortage of internes and house physicians in our hospitals, many duties formerly carried entirely by them are being delegated to the nursing staff. Nurses have already been required to assume responsibility for laboratory and x-ray work, giving intravenous injections, and numerous other such tasks, in order that the day-by-day business of nursing the patient may proceed.

Tuberculosis sanatoria and psychiatric hospitals present a vast field for nursing service. We cannot begin to fill the nursing needs of these two special types of hospitals in Canada at the present time. Opportunities for utilizing special training in these branches are legion. In an early issue of the *Journal* will appear the names of the hospitals offering graduate training in these specialties.

The Victorian Order of Nurses offers wide opportunities for those interested in bedside nursing in the home, with the added interest of the various activities included in a general public health nursing program. Public health nursing positions are literally going begging for the want of nurses. It is no exaggeration to say that a thousand public health nurses are needed right now in Canada. Provincial and city departments of health have positive plans for extension of health services which are being delayed only because personnel, both medical and nursing, is unavailable. Industrial nursing is practically a virgin field in Canadian industries. War industries have stimulated more extensive health services in many plants, which it is hoped will be maintained in peace-time.

These are only the highlights of opportunities open to our nurses in our homes and hospitals. Further opportunities will be noted from time to time on this page of the *Journal* with the development of a placement service bureau (that is, employment bureau) in each province. It should be increasingly easier to obtain special information concerning positions available in all types of nursing service. Write to your Provincial Secretary, or the Superintendent of the hospital in which you wish to work, or to the Secretary of the Committee on Postwar Planning, National Office, Canadian Nurses Association, stating your special nursing interest, preparation, experience, etc. Thus we will know where you are and what you want to do and then the requests for nurses with your experience, preparation and capabilities can be filled.

What Local Associations Can Do to Step up Student Nurse Recruitment

E. A. Electa MacLennan

The most effective method of recruiting — for nursing, as for anything else — is personal contact. Local associations are in a better position than are the Provincial Associations or the National Association to employ this most effective of all recruitment methods. This does not mean that members of local associations should conduct a house-to-house canvass! But they can make

the need for student nurse recruits a matter of *personal* concern to the members of their community.

One of the obvious methods of conveying information to groups within the community is through addressing them at their meetings — Young People's meetings, meetings of women's organizations and of men's service clubs. Copies of a Speakers' Handbook, especially prepared for the use of nurses and student nurses, are available on request from the national or from your provincial association. An easy way of giving information in an interesting manner is through panel discussion. Several voices in discussion are more attention-holding than one voice, especially if the several voices are of people known to the audience. The national association has available scripts using student nurses and high school students. These scripts have been prepared for radio, but they are equally suitable for use in panel discussion.

If there is a radio station in your community, you might be able to get some free radio time for the presentation of one of these scripts over the air. If you obtain copies of the scripts and take them to the station manager, he will be able to see exactly what you propose to do, and if he is community-minded, as most station managers are, he is likely to be very co-operative. The national association has in preparation 15-minute radio plays dealing, in an entertaining manner, with the life of a class of student nurses. These plays are being recorded, and recordings will be available to radio stations wishing to use one, several or the complete series (about ten) of the plays. If you are interested in these, write the national office, and they will advise you when recordings are available.

You can usually obtain excellent co-operation from your local newspaper. Releases are mailed to newspapers by provincial and national offices, but, in addition, you might interest your town paper in doing a feature article on the local situation. As an example — the Montreal *Herald*, at the time of writing, is preparing a feature on nursing to tell, largely in picture form, the story of the life of a student nurse and to give an indication of the work she may do as a graduate nurse. A similar article, with photographs taken at a local hospital school of nursing, would have great interest for any newspaper's local readership.

Any of these student recruitment efforts — talks, panel discussions, radio programs, newspaper features — might very appropriately be timed for Hospital Week. Something that has been tried and found very successful as a Hospital Week feature is the visiting of the local hospital by girls from high school graduating classes. If your local hospital has a school of nursing, you might arrange to have the student nurses entertain the high school girls at tea and conduct them through the residence and hospital wards. Even if your local hospital has no school of nursing, you might arrange to have a high school group visit the hospital to get some indication of the work of the hospital staff nurse and to arouse interest in nursing as a profession.

The problem of making adequate nursing care available to all who may require it is the problem of all members of the nursing profession. Anything your local association does to encourage student recruitment helps to solve this problem both for the present and the future.

The national office, as you may know, employs publicity counsel, through whom the material above referred to has been prepared, and local associations are invited to take advantage of services and material thus made available in planning their own student recruitment programs.

Counting up the Costs

War is an extravagantly costly business. For the past five and a half years we have been hearing of expenditures so vast as to be almost astronomical. Millions for planes, millions for ships, for ammunition, for uniforms, for food. We get a bit bored when the figures become so large — we can't quite imagine so much money. Perhaps if we think of expenditures in terms of the things we, as nurses, know best — hospital equipment, dressings, drugs — we will get a clearer picture of why it is so important that we keep right on buying Victory Bonds. Some of these data were given in the November *Journal* but the figures bear repetition: Sufficient penicillin to treat one major case, $50; one wall plate for muscle and nerve testing, $100; ultra violet quartz lamp, $250; emergency operating room light for use in case of power line failure during an operation, $300; combination set of hospital sterilizers, $1000; high-pressure steam disinfecter for sterilizing blankets and mattresses, $2000; complete major x-ray unit, $5000.

Those are just a few of the more costly items you say. Alright, no hospital is complete without beds. It takes $15,000 to supply a thousand of them, complete with mattresses. Dressings by the thousands must be available. One hundred thousand of them cost $10,000. Adhesive plaster is such an essential commodity for a wide variety of purposes. Thousands of yards of it must be ready for use. When we realize that one fifty dollar Victory Bond will furnish only two thousand yards of two-inch adhesive, we can see why so many individuals must assist in this problem of financing the war by buying as many Bonds as their means will allow.

How can the nurses of Canada assist in making the Eighth Victory Loan drive an outstanding success? First, by their individual purchases. If each nurse

Canadian Army Overseas Photo

Underground hospital in Holland.

bought only one fifty dollar Bond, it would represent a very large amount of money since there are over twenty thousand active, practising nurses. Second, by sponsoring the purchase of Bonds through their nursing associations ranging from the smallest local chapter to the large parent body. Such investments will not only bring in a tidy sum in interest to the association but will also be useful as the nucleus for post-war organization activities which may be planned. Alumnae associations might use their purchases toward the setting-up of scholarship funds.

Finally, the nurses may call the attention of their friends to the rapidly increasing demand for hospitals and equipment to care for the steady stream of wounded men. The termination of the war in Europe will not bring the need for all of these facilities to an end. Let each of us be sure that no care shall be wanting because we have failed. In this spirit, the Eighth Victory Loan will be as successful as its predecessors.

R.N.A.P.Q. Reaches its Silver Jubilee

On February 14, 1920, "an Act to incorporate the Association of Registered Nurses of the Province of Quebec" was assented to by the Lieut. Governor of the Province, thereby creating the only bilingual professional nurses association in North America and the second in the world, our counterpart being the South African Nursing Association where English and Dutch are the official languages.

Last December a special meeting of the Committee of Management was held to which were invited all former presidents of the Association and others who have contributed outstanding service to the Development of our Association. Plans were drawn up for a suitable celebration of our twenty-fifth anniversary.

Realizing that any plans made in advance would be conditioned by the changing world scene, it was unanimously decided that the actual birthday (Feb. 14, 1945) would pass unnoticed and that special features would be included in the annual meeting. It is planned, therefore, that our Silver Jubilee will be celebrated on May 28, 29, 30, beginning with church services on the 27th, our fourth National Memorial and Rededication Service to be held in St. George's Church, Montreal, at 7 p.m. and 9.30 a.m. in the Chapel of old Eglise Bonsecours.

On *Monday, the 28th* sessions will be held in the afternoon and evening in the Windsor Hotel. These will be bilingual and will include the president's address, and reception and discussion of reports covering our many activities.

On *Tuesday,* sessions in English and French will be conducted separately. Program plans for the afternoon are as follows: *English* session: Gertrude Hall and Rae Chittick will be the speakers, their topics being: "Two Types of Nurses" and "The Role of the Nurse in Canada's Rehabilitation Program". *French* session: Dr. Edouard Desjardins, Dr. M. C. E. Grignon, and Rev. André M. Guillemette will present: "Ce que le public attend de nous"; "Les glandes endocrines et la personnalité"; and "Techniques modernes pour la Protection de l'Enfance".

In the evening there will be a "Forum on Current Events as related to Canadian Nursing" conducted separately in adjoining halls in each language. The topics will be "Legislation" by E. Flanagan; "Labour Relations" by E. Beith and E. Rocque; "Postwar Planning" by M. Lindeburgh and J. Trudel. Discussion is to be lead by F. Munroe, G. Hall, R. Chittick, M. Kerr. E. Johns, E. MacLennan. Rvde Sœur Lefebvre, M. Roy, M. Beaumier, M. Taschereau, J. Lamothe, E. Cantin, A. Robert, A. Martineau, A. Albert, and E. Gauvin. On Wednesday afternoon, the forum of the previous evening will be repeated at Hotel-Dieu for the sisters.

A banquet at 8 o'clock in the Windsor Hotel will bring the meeting to a close. At this time we anticipate including among our guests the members of the Executive Committee, C.N.A., whose meeting, will open in Montreal the following day.

E. Frances Upton
Executive Secretary and Registrar.

Saskatchewan Nurse Instructors Hold an Institute

GRACE GILES

"Wouldn't it be a help to us inexperienced instructors if we could all get together and talk over our problems and share our ideas", said a bright young instructor in one of our nursing schools. And that was how it all started. Miss K. W. Ellis, adviser to schools of nursing, discussed the proposal in the schools as she visited; so did the travelling instructor. Our president, Miss M. Diedrichs, and the Council members felt it would be a very worthwhile project for the Saskatchewan Registered Nurses' Association to sponsor. Everywhere there was an enthusiastic response. The instructors welcomed the thought of a pause in their heavy winter program when they might drop the routine for a few days and find new inspiration for the months ahead. Busy administrators willingly agreed to make the necessary arrangements. They realized, they said, that it was more often the superintendent of nurses than the instructor who was able to attend the provincial convention, and that there are many subjects directly related to teaching which there is never time to bring up at an annual meeting. So with the co-operation of the superintendents of nurses and, in many cases, financially assisted by generous donations from the hospital boards, the instructors from all the ten hospital schools of nursing in Saskatchewan met in Saskatoon for the first Institute for nurse instructors to be held in Saskatchewan. Miss Ellis, director of nursing, represented the University School of Nursing.

It was decided to hold the institute before the spring preliminary classes were admitted. Knowing that the instructors had little time for special preparation, the program was planned with a view to having a large part of the 'inspiration' come from outside the group. However, one or more nurses from each hospital came prepared to contribute to topics in which they could help one another better than could someone from another profession. Another guiding principle in planning the program was to try not to give material which the nurses had already had in post-graduate courses. All the instructors had had at least one year of post-graduate work in a university nursing school, and the following universities were represented by the group: McGill, Toronto, British Columbia, Manitoba, Alberta and St. Louis.

The spirit of co-operation displayed by nurses and those in other professions, who were asked to participate in the project, was a great satisfaction. One young lady, a director of a teen-age centre, said, "I will be glad to try to give some suggestions for planned recreation for student nurses. I have just come out of hospital myself, and I *like* nurses."

The superintendents of nurses in the two hospital schools of nursing in Saskatoon graciously arranged for the meetings to be held in their classrooms. There were visits to various departments in both hospitals too. One meeting was held in the University of Saskatchewan. At the City Hospital a most interesting demonstration of equipment and techniques on a children's ward had been prepared, while, in the polio clinic at St. Paul's Hospital, a demonstration of the "Kenny hot pack" was given. Displays of artistic posters which had been prepared in connection with history of nursing, professional adjustments and personal hygiene, furnished new ideas. One of the head nurses contributed some of her material for clinical teaching. This included an outline of her program and an indexed box with information on new drugs.

Several book publishers very kindly

sent books for the instructors to look over, and these proved a real centre of interest. A number of films loaned by the Audio-Visual Branch, Department of Education, were greatly appreciated. One of these entitled, "Nursing", is being used in vocational guidance work in the province. Information on sources of films suitable for nursing schools was given during the institute. A number of schools have their own movie projectors.

When arrangements for the institute were being made, the instructors were invited to send in questions in advance which they would like to have discussed. These were all combined and sent to each school for consideration before the meeting. Several lively discussions arose out of the "Question Box". Somebody said, "Should nurses' marks be posted?" Most instructors thought they should be. The objection was raised that it tended to discourage the poor student. So it was suggested that one might post the results as grades, A. B. C. D. etc., and record the actual marks in the records. Then there were the "New Ideas and the Time Savers". Both of these proved very popular. One instructor arranges a reserve shelf in the library whenever she gives a special assignment. On it go the books and other references which have been given. It saves precious minutes for the students. Making the technique of intravenous injection more realistic, by a piece of fine rubber tubing attached by adhesive to the arm and forearm of the doll, and extending up under the shoulder and into a bottle concealed at the head of the mattress, was another suggestion. How to use old books for illustrative material to use in the lantern was shown by a young nurse-teacher fresh from her university post-graduate course. One very experienced instructor described how she had secured the necessary equipment for a bacteriology laboratory at little expense, and explained what interesting cultures could be obtained from an infusion of hay. She uses washings from grapes to demonstrate yeast cells. Space forbids mention of any further suggestions but you can see how helpful the discussions proved to be.

A symposium on skin demonstrated the correlation of various subjects, and included the anatomy and physiology of skin from a functional viewpoint, drugs and solutions as they relate to the skin, and bacteriology in relation to the skin. A talk on "Common Diseases of the Skin" was given by a skin specialist, and the symposium ended with a demonstration dressing of a skin lesion. The group listened with much interest and pleasure to a very helpful talk "On Teaching Pharmacology", especially when the speaker, with a twinkle in her eye, made such a point as warning her fellow instructors not to try to cram in too many drugs or they could expect their students to show serious symptoms of overdosage. Ward teaching held everyone's attention for two periods — one when a group of nurses successfully dramatized a nursing clinic, and again, when a supervisor in charge of a children's ward outlined her plan of clinical teaching based on the eight-weeks' period the students are in her department. Another profitable hour was spent in learning how to make the nursing school libraries more valuable to students. This was contributed by a librarian from the Saskatoon public library.

There were three splendid lectures by Dr. S. R. Laycock of the College of Education, University of Saskatchewan. After Dr. Laycock's talk on some of the hazards in classroom teaching, one of the instructors, remarked, "Never again will I greet my class with — Today we're going to study digitalis. Instead, I'll begin — How is Mr. Smith, up on ward B, the one who is receiving digitalis I mean"? Dr. Laycock made us all resolve to do better teaching. Equally stimulating was Dr. D. M. Baltzan's lecture on psychological medicine, illustrated in a most original manner. Having Dr. Baltzan with us was of special interest because his book, "Internal

Medicine for Nurses" will shortly be off the press and is to be used by a number of our schools of nursing as a textbook.

Instructors also need help with extracurricular programs, and the following topics proved both refreshing and stimulating, "Developing a Taste in Reading", "Interior Decorating", "Flower Arrangements", "Nurses must have a Little Fun". There were extracurricular activities at the institute too — a luncheon party at the Bessborough Hotel, afternoon tea each day, and a specially delightful formal tea on the last afternoon which was given jointly by the two hospitals.

During the week of the institute special efforts to interest the public in nursing and its possibilities as a profession were made. A very attractive series of posters on "Opportunities in Nursing", which had been lent by the R.N.A.O., was displayed in a window of a large department store. A nursing 'trailer' was run at one of the local theatres, while in the lobby a figure poster of a nurse urged those who might make nursing their career to take the information which her little box contained. Considerable newspaper publicity was also given to the institute.

Was our institute worthwhile? We think so. We have all become acquainted and shared our problems — rather astonished at times to find how similar they are. We have learned much from each other, and experienced the stimulation of hearing from specialists in other fields which have a bearing on our work. Already we are making plans for next year. There were questions we could not settle because we did not have enough information, so we have to do some research before we meet again.

Repairing Old Skeletons and Manikins

Old skeletons may be repaired with plastic wood (and much patience) and may serve to tide over until replacements may be secured. The edges of chipped bone should be painted with Duco household cement, which should be allowed to harden. This acts as a filler for the plastic wood which can be applied and shaped to fit the cavity present. After drying, more cement and a little of the wood can be worked down into the crevices with a toothpick. Skeletons can thus be salvaged temporarily and correct anatomy can be taught.

Manikins can be treated much in the same way. The surface of the dried wood can be colored with crayons or paint after it has been built up to the desired height.

An incorrect bone makes learning difficult for the student, as she has no background on which to base her knowledge and supposes that every hole and cavity is natural to the bone. Completely discarded skeletons may be disarticulated and the bones repaired to make adequate specimens for classroom purposes.

It takes time, but is not costly, and in some cases may be worth the effort, since new specimens are so difficult to obtain at present.

—Davis' Nursing Survey

Royal Canadian Naval Nursing Service

A conference of Matrons was held recently at Naval Service Headquarters. This conference included Matrons from R.C.N. hospitals across Canada and Newfoundland. A Special Treatment Centre has been opened at Ste. Agathe des Monts and is staffed by R.C.N. Nursing Sisters.

N/S F. Rutledge (Toronto General Hospital) has been appointed Acting Matron, St. John's, Newfoundland.

STUDENT NURSES PAGE

Gas Gangrene

BERNICE HALEY

Student Nurse

School of Nursing, Brantford General Hospital

Mr. B. is a small, dark, somewhat emaciated fifty-year-old Frenchman. He is married, though his wife and six children live out of the city. The patient works at a war plant and lives at a men's hostel but states that he gets home quite frequently. He is a devout Roman Catholic, is interested in sports, but likes to spend as much of his spare time as possible with his family. Many of his associates and fellow-workmen, who enquired for him, stated that the patient is an excellent workman and has a friendly, cheerful personality. He attended school until he was sixteen years of age and reached Grade X.

This man was working at the plant when a glue-pot exploded and a piece of iron struck him. He received a severe laceration on his left leg below the knee, a small puncture wound in his right leg above the knee, and a comminuted fracture of his right leg between the knee and the hip. The doctor who examined him in the first aid room advised hospitalization.

On admission to the hospital ward at noon, the patient's dye-stained, soiled clothes were removed and he was placed in a previously warmed bed. He was in a condition of shock, showing symptoms of pallor, cold, clammy perspiration, thready pulse and extreme weakness. He was given a warm drink, hot water bottles were placed around him and 500 cc. of blood plasma was started. At 2 o'clock the patient suffered a chill, the reaction temperature being 100.8. When he was sufficiently recovered from the chill, a Balkan frame was erected, a portable x-ray machine was brought to the ward, and an x-ray of the pelvis, including both femurs, showed the comminuted fracture of the right femur at about the junction of its middle and distal third. The fragments were in good position.

The puncture wound was cleansed with green soap and a sterile dressing applied. A Thomas splint with Buck's extension was placed on his right leg.

The laceration on his left leg was cleansed with green soap, the surrounding area was painted with iodine 2½ per cent, novocaine ½ per cent was injected close to the site, sulfathiazole powder was placed in the wound which then was sewn up with dermal sutures, three drains having been inserted. A dry dressing was applied. Tetanus antitoxin, 1500 units, was given, the patient's blood pressure was taken every four hours during the night and morphine sulphate, gr. ¼, was given hypodermically every four hours, if necessary.

The following day Mr. B began complaining of abdominal discomfort and had difficulty in voiding. He had

voided only small amounts since the accident. Catheterization relieved him of thirty-six ounces of urine.

Two days later laboratory studies revealed a leukocyte count of 8,300 per cu. mm. of blood with a differential count of 83 per cent neutrophils, 12 per cent lymphocytes, and 4 per cent monocytes. The concentration of hemoglobin was 65 per cent of normal; erythrocyte count was 4,150,000 per cu. mm. of blood. Blood cultures obtained from the wound on the left leg revealed chlostidium welchi and staphylococcus. A direct smear revealed a moderate number of pus cells and many gram-positive bacilli resembling cl. welchi. Bacillus welchi is a short, gram-positive, non-motile rod. In tissues, it develops a thick capsule. It is present in the intestinal tract of man and most animals. Because it forms spores, it survives outside the body and lives for a long time in fertilized soil. It is essentially a saprophytic organism which becomes pathogenic only when introduced in large numbers, when foreign bodies are present, or when there is considerable destruction of tissue, particularly muscle tissue, which offers a favourable environment for growth and toxin production. B. welchi grows readily in laboratory culture under anerobic conditions. The organisms ferment muscle sugar, cause formation of gas bubbles which, by their presence, disrupt the tissues and carry the infection farther into the body. Perfringens antitoxin, which is a gas gangrene antitoxin prepared from the blood plasma of horses, highly immunized against the toxins of bacillus welchi, was administered intramuscularly in doses of ten thousand units daily for four doses.

"Gas gangrene infection is characterized by profound intoxications — abrupt rise in temperature, then high fever, rapid pulse, prostration and apprehension. Locally, there is pain in the wound, redness, swelling, bronzing of the skin and crepitation, which is due to the generation of gas by the action of the organisms on the muscle tissue. As the bacilli grow they form gas and also a poison of enormous potency; these poisons with the gas enter the blood. Two poisons are formed, one causing blood destruction or hemolysis, the other acting locally and causing edema and necrosis. Until late in the case the blood does not contain the bacteria because of its oxygen content which inhibits the growth of anerobic micro-organisms. Probably the presence of gas in the blood explains the sudden death of many patients.

Gentle pressure on the margin of the wound usually produces a sanguino-purulent exudate in which gas bubbles may be seen. X-ray frequently demonstrates gas in the tissues, and it may be heard by stethoscope. The muscles become soft, mushy, and dark red. Neutrophilia or increase in the absolute number of neutrophilic cells in the blood is common, the normal being about 3000-7000 per cu. mm. of blood, or 60-75 per cent. When well established, the infection travels very quickly up the muscle, and up to a few years ago only surgery could have saved life, and this only if the case were seen early. Backache, headache and the formation of vesicles on the skin near the wound are characteristic of a well-established infection.

Mr. B was a typical case. His temperature rose within twelve hours from 99 to 101.2 degrees. His pulse ranged well over the rate of 90, at times rising above 100. The patient looked pale, and was very worried regarding his condition, calling himself a "sick man" and showing great apprehension. At nights, he would groan loudly with the pain in his legs. The wound appeared inflamed, while sanguino-purulent exudate containing gas bubbles oozed on pressure.

Urinalysis reports showed a trace of albumin and the presence of blood cells. The patient's neutrophil count was 83 per cent. Sulfadiazine gr. XV was given every four hours for twenty-seven doses, and then reduced to gr. VII every

four hours. It is not known definitely how valuable sulfa drugs are in the treatment of gas gangrene, but it is thought that they are beneficial.

The same day the administration of penicillin was begun. Penicillin is a potent, anti-bacterial substance obtained from the culture liquor of the mold *penicillium notatum*. It is relatively non-toxic for tissues and can be administered intravenously, intramuscularly or locally. It acts principally on gram-positive bacteria, having a bacteriostatic action. Following an injection, penicillin is rapidly excreted by the kidneys, the blood stream being practically cleared of it in from two to three hours, thus the interval between doses should not exceed three hours. Penicillin should not be used as an irrigating solution, as it must remain in contact with the infecting organism for at least six to eight hours before it exerts anti-bacterial effect.

Penicillin came to the ward in a sterile vial and was in the form of an amorphous yellowish-brown powder. The vials we used contained 100,000 Oxford units. This was dissolved in 20 cc. of distilled water, the finished solution being 5,000 units of penicillin per cc. of solution. It was prepared and stored under aseptic precautions and made freshly every day, as it is of no value after 24 to 48 hours in solution.

Mr. B received 15,000 units of penicillin every three hours for eight days, receiving 600,000 units intravenously and 460,000 units intramuscularly. He also received 40,000 units locally into the laceration on his left knee.

The dressings on the infected wound were changed every day by the doctor, and the wound was syringed out with hydrogen peroxide. Hydrogen peroxide is a liquid which is a chemical composed of equal parts of hydrogen and oxygen. It decomposes when it comes into contact with organic matter such as pus or blood. It then yields bubbles of oxygen which destroy the anerobic bacteria with which it comes in contact. At the same time it helps to loosen membranes and pieces of dead tissues. The more pus or dead tissue present, the more oxygen will be liberated.

Mr. B was strictly isolated throughout his illness. His linen, after use, was soaked in H.T.H. 15 solution 1/5 per cent for five minutes; his silverware was soaked in sterilol 5 per cent, and his dishes were soaked in H.T.H. 15 solution 1/10 per cent for five minutes. He had a separate dressing tray, and the instruments on this were always soaked in sterilol 5 per cent for half an hour then boiled after use. The patient was kept screened continuously. The doctor thought it advisable not to move him because his right leg was in good position and the moving might move the fragments out of place.

Mr. B is now much improved. His temperature, pulse and respiration are almost normal, and he has changed from the "agitated, sickly looking man" to one of a pleasant personality with a good sense of humour.

His prognosis is good as the wound is healing nicely, infection clearing away, and the right fracture appears to be knitting satisfactorily. After a short rest at home following discharge from hospital, he will probably go back to his work "as good as new."

My health teaching consisted in pointing out to the patient the "importance of a daily bath, and regular elimination". I taught him to clean his teeth morning and evening and develop good oral hygiene, as he had marked dental caries on admission. I tried to stress the importance of a well-balanced diet, and good noon-day lunches for a working man.

This study was interesting to me because in wartime we read that gas gangrene is responsible for many deaths among the casualties. The shrapnel wounds infected from bacillus welchi which is found so commonly in the soil tends to produce gas gangrene. I was interested to read an article in the *Me-*

dical Digest which stated that lives threatened by gas gangrene infections may be saved if a new chemical test proves successful. This test depends on detecting in the fluid, excreted from the wound, the presence of enzymes or ferments produced by the germs which cause gas gangrene. By using an ordinary white blood cells counting pipette, with a few simple precautions, the test can be carried out on the battlefield and the results obtained in one hour.

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The Manitoba Student Nurses' Association

The Manitoba Student Nurses' Association, sponsored by the Manitoba Association of Registered Nurses, is the first provincial organization of its kind. It is anticipated that through fellowship of this type student nurses in the province may develop an understanding of and prepare themselves for active participation in the broader fields of professional interests following graduation.

The first meeting was held last November in Winnipeg. Representative students from eleven schools of nursing were guests of members of the Board of Directors, Manitoba Association of Registered Nurses. This meeting took the form of a buffet supper and gave everyone an opportunity to mix socially. Our convener, Miss Frances Waugh, assisted with the planning of the first meeting and will act in an advisory capacity.

Our objectives are as follows:

1. To set up a body recognized as the official representation of student nurses in the province on a comparative basis with other such organizations, etc.

2. To stimulate interest and disseminate formation about current events in the world of nursing, with particular reference to activities within the Manitoba Association of Registered Nurses, the Canadian Nurses Association, and the International Council of Nurses.

3. To provide a means of broadening the cultural background of student nurses that they may be more adequately prepared for the part they must play as citizens in a community.

4. To form a natural means of progress from the Junior Association into the Manitoba Association of Registered Nurses, when the member becomes eligible, with an appreciation of the significance of that membership.

5. To promote a spirit of unity, and a common bond of understanding and of mutual helpfulness in the student nurses of this province.

The first mass meeting held in December was most successful. Over one hundred students from various hospitals attended. Our guest speaker, Miss L. Pettigrew, president of the Manitoba Association of Registered Nurses, interpreted our relationship with the Manitoba Association of Registered Nurses, Canadian Nurses Association, and the International Council of Nurses, explaining the interests of these to us professionally envisioning the expansion of organized student nurses groups on a national and perhaps international scale.

We hope that we may attain our objectives in time, as a recognized Association, and through our achievements prove the value, professionally and personally, of under-graduate affiliations with the senior organizations.


Please, nurse, don't tuck me in without my Z.B.T. powder!
Z.B.T. Baby Powder clings long and protectingly to baby's tender skin. Its smooth, downy-soft film helps to guard against chafing, prickly heat, diaper rash and other minor skin irritations.
Z.B.T. contains olive oil. Feel its superior "slip" as you rub a little between your fingers. Z.B.T. is moisture resistant too, an important baby powder advantage.
Z.B.T.
BABY POWDER
WITH
OLIVE OIL
Make this convincing test with Z.B.T. containing Olive Oil
Smooth Z.B.T. on your palm. Sprinkle water on it. See how the powder doesn't become caked or pasty. The water doesn't penetrate it, but forms tiny powder-coated drops—leaving the skin dry and protected. Compare with other leading baby powders.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Maxine Bow (University of Alberta Hospital; B.Sc.N., University of Alberta) has been appointed to the Montreal staff.

Mrs. Marjorie Salter (Ottawa Civic Hospital) and *Margaret Joyce* (University of Ottawa School of Nursing), having completed the two months' period of orientation in Victorian Order nursing on the Toronto staff, have been posted to the York Township and Trenton staffs respectively.

Edith Horton has resigned from the Kitchener Branch to accept a position as school nurse at the Collegiate Institute, Ottawa. *Madeline Firby* and *Bessie Julien* have resigned from the York Township staff, the latter to work as a missionary in the Foreign Mission Field. *Hazel Dobson* has resigned from the Vancouver staff to accept a position in the Hospital for Crippled Children, Vancouver. *Essie Kain*, nurse-in-charge of the Porcupine Branch, has resigned to accept a position with the Ontario Provincial Department of Health.

Margaret Oulimar has been transferred from the Amherst to the Montreal staff. *Jeanne Bertrand* has been transferred from the Montreal staff to take charge of the Lachine Branch.

Mabel Barry (Saskatoon City Hospital) and *Alyce MacKenzie* (Jeffery Hale's Hospital, Quebec), having completed the two months' period of orientation in Victorian Order nursing on the Montreal staff, have been posted to the Regina and Sarnia staffs respectively.

Ontario Public Health Nursing Service

Clara Kittmer (Woodstock General Hospital and University of Western Ontario public health course) has resigned her position with the Middlesex County School Health Unit to accept the appointment of public health nurse at Paris.

Mary Murdoch (Saint John General Hospital, N.B. and University of Toronto public health course) has resigned her position at Owen Sound to accept the appointment of public health nurse at Thorold.

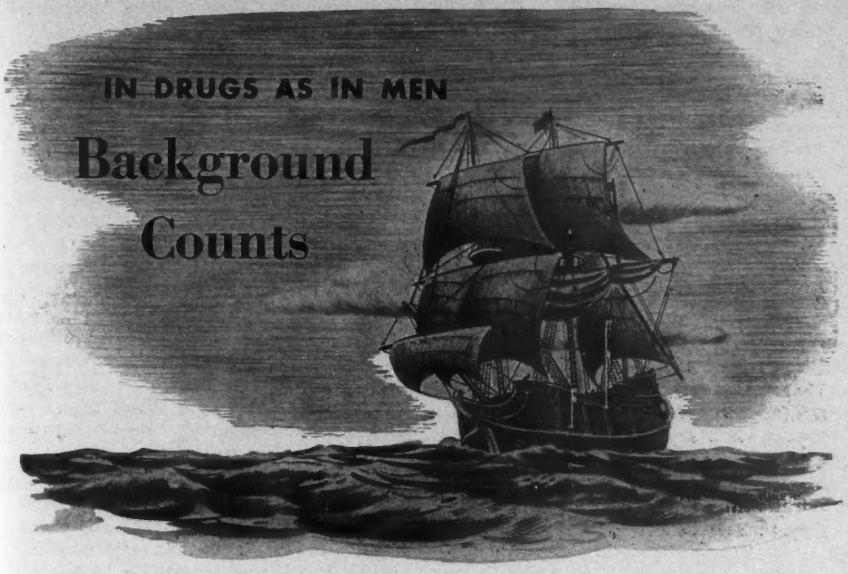
Helen Kirk (Victoria Hospital, London, and University of Western Ontario public health course) has resigned her position with Middlesex County School Health Unit to be married.

Florence Bell (Victoria Hospital, London, and University of Western Ontario public health course) has resigned her position at the Toronto East General Hospital to accept an appointment with the Middlesex County School Health Unit.

Book Reviews

Lest We Forget, edited by Annette Wellesley-Smith, in collaboration with E. L. Shaw. 28 pages. Printed by The Premier Printing Co. Pty. Ltd., 27-31 Little Bourke St., Melbourne, Australia, for the Australian Army Nursing Service. Price Two Shillings.

Commemorating the eleven courageous nurses who lost their lives in the sinking of the Australian Hospital Ship *Centaur* by an enemy submarine, the Australian Army Nursing Service has had this small booklet prepared to help to raise funds for the Centaur Memorial Scholarship.



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In her editorial, Lieut.-Col. E. Lydia Shaw, Principal Matron, A.A.N.S., says: "In order that we may perpetuate their memory in a way which will live, a fund has been established, the interest from which will provide a scholarship in post-graduate nursing, which will educate trained nurses to fill advanced teaching and executive positions".

After describing briefly the tragedy of the sinking, there are concise accounts of the work the Australian nurses have been doing in the various theatres of war including the Middle East, Colombo, Malaya, New Guinea, etc. Speaking of the work of the A.A.N.S. General Sir Thomas Blamey, G.B.E., K.C.B., C.M.G., D.S.O., E.D., Commander-in-Chief, Australian Military Forces, said: "Their great courage and their high standard of service . . . has won them the great admiration and affection of the troops they tend so selflessly".

Introduction to Microorganisms, by LaVerne Ruth Thompson, M.A., R.N. 445 pages. Published by W. B. Saunders Co., Philadelphia & London. Canadian agents: McAinsh & Co. Limited, 388 Yonge St., Toronto 1. 1st Ed. 1944. Price $3.25.

Reviewed by Dr. L. E. Ranta, Assistant Professor, Dept. of Preventive Medicine, University of British Columbia.

From the wider atmospheres of preventive and curative medicine this book successfully extracts the essence of bacteriology and immunology. Throughout, emphasis is placed upon the effect of the life functions of microbes on animate and inanimate environments; in other words, this book offers the elementary "dynamics" of microbiology. Nurses, especially prospective public health nurses, social service workers, and home economists should find the presentation clear, useful and stimulating.

Microbiology-Instructress Thompson (Division of Nursing Education, Teachers College, Columbia University) presents her subject under five main headings: (1) "Life in Miniature" views the structure, metabolic function and reproduction of microorganisms; (2) Bacteria and the Environment" discusses the main chemical and physical characteristics constituting favourable and unfavourable conditions for bacterial development; (3) "Parasites and the Host" begins with the mechanisms of infection and of host resistance, and then points out the necessity for alert community, home and hospital sanitation; (4) "The Pathogens" deals both with the procedures used to isolate and identify pathogenic bacteria, and with the common pathogens in action, arranged in groups according to similarities in modes of transmission; (5) "Man Against Parasites" offers a brief history of the scientific advances in preventive medicine from ancient to modern times, from individual to community responsibility. Each of the first four units is concluded by a group of laboratory experiments designed to emphasize the conclusions to be drawn from the text. The final unit is followed by an appendix describing the use of microscopes. The book ends with an adequate index of twenty-four pages.

The text is illustrated by a few excellent line drawings by Mrs. P. C. Baker; in particular, the artist deserves commendation for the clever and attractive chapter-headpieces. It is to be hoped that post-war editions will find space for more of Mrs. Baker's work and, perhaps, for some additional subject-matter. For example, no mention is made of the encephalitides and equine encephalomyelitis, of the microbiological assay of B-group vitamins, or of the importance of preparing bacterial vaccines from fully virulent or otherwise suitable strains. Furthermore, the chapter devoted to "Organisms Transmitted by Food and Water" might be clarified by drawing a clear-cut distinction between food infections and food poisonings, and by removing all the Salmonella infections from the latter category. In this chapter the epidemiological value of bacteriophage typing of *E. typhi* receives no attention and staphylococcal food poisoning is erroneously attributed to enterotoxic irritation of the stomach and intestines, rather than to action upon the "vomit-centre" in the brain. The chapter on "Chemotherapy" deserves expansion and, therein, *p*-aminobenzoic acid,

a newer member of the vitamin B group, should not be referred to as "one of the essential amino-acids."

The foregoing criticisms should not detract from the merits of Miss Thompson's book, rather they indicate that it both enjoys, and suffers from, freshness. It deserves a place among those textbooks on microbiology especially designed for student-nurse education.

Fevers for Nurses, by Gerald E. Breen, M.D., Ch.B., D.P.H., D.O.M.S. 206 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1944. Price $1.50.

This text is based upon the syllabus drawn up by the General Nursing Council for the training of student nurses. The majority of the acute communicable diseases are described in some detail in simple language. As well as outlining the distinctive features, complications and treatment of a considerable variety of these diseases, the author indicates special infections which may affect the sense organs and skin, and certain operative procedures, including tracheotomy, drainage of empyema and suppurating glands, etc. A selection of examination questions on this topic are included in the final chapter.

NEWS NOTES

ALBERTA

EDMONTON:

The annual meeting of Edmonton District 7, A.A.R.N., was held recently with Helen McArthur presiding. Election of officers for the ensuing year took place. Ida Johnson made a presentation to Elizabeth Pearston, registrar of the A.A.R.N. who has resigned and is taking up new work in Saskatchewan.

Edmonton General Hospital:

The annual banquet of the Edmonton General Hospital Alumnae Association was held recently with Mrs. R. J. Price, the president, presiding. Seated at the head table were: E. Matthewson, instructress; Mrs. E. Frazer, honorary president; Mrs. J. Loney, first vice-president; Mrs. W. McCready, second vice-president; Mrs. D. Edwards, treasurer; V. Protti, recording secretary; Mrs. J. G. Kato, corresponding secretary; the standing committee consisting of: Mrs. E. Barnes, convener, assisted by E. Bietsch, Mmes J. Hope, J. Kerr, and Miss J. Richardson.

Rev. Sr. O'Grady, superior, and Rev. Sr. Keegan, superintendent of nurses, welcomed the graduates. Miss Bietsch presided as toast mistress. The toast to the King was proposed by Mrs. Frazer and the toast to the training school was proposed by Mrs. Price. The speakers were Mrs. Price, who presented the program for 1945, and Miss Matthewson. A presentation was made to Mrs. Frazer, past president. Student nurses served and presented a short musical program.

Royal Alexandra Hospital:

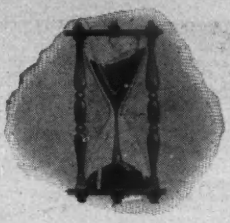
The Royal Alexandra Hospital Alumnae Association held a regular meeting recently with Violet Chapman presiding. About one hundred members were present. Plans were made for a bridge with Mrs. M. H. Thompson as convener, assisted by Mmes T. R. Clarke, J. Rowlatt, and Miss M. Griffith. Dr. Graham Huckell was guest speaker and showed films of an orthopedic hospital in Scotland to which he was attached.

At a later meeting plans were made for the annual banquet in honour of the graduating class. Mrs. W. Norquay is convener, assisted by I. Johnson, A. Lysne, and A. Swift. Plans were also made for a bazaar to be held in the Fall. V. Chapman was appointed delegate to the A.A.R.N. annual meeting. Mr. Harold Weir, president of the War Services Council for Northern Alberta, was guest speaker and gave an address on "Current Events".

BRITISH COLUMBIA

CRANBROOK CHAPTER:

The annual election of officers for the Cranbrook Chapter, R.N.A.B.C., was held



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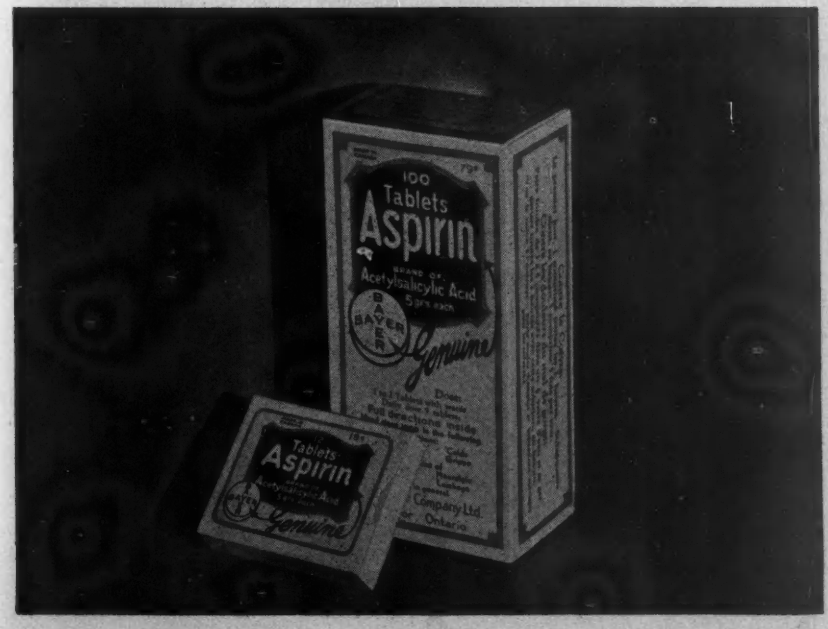

recently when Mrs. A. B. Smith's resignation as president was accepted reluctantly. Since the inauguration of the Cranbrook Chapter Mrs. Smith has given her full co-operation to its development and objectives. Our most sincere vote of thanks was extended to her as she referred her offices to Mrs. J. C. Little whom the Chapter heartily welcomes. Two additional members will be on the executive this year — a vice-president, C. Podbielancik, and a treasurer, Mrs. R. Pelton. The Chapter is happy that A. McClure has consented to retain the office of secretary, and that Mrs. C. T. Rendle will remain the convener of the program committee. Mrs. T. J. Sullivan is social convener.

The good preparation of program material has contributed effectively to the success of our meetings. A review of several nursing procedures brought about interesting discussions among both the older members and the new graduates. A lecture was given by Dr. W. O. Green on "Intravenous Injections and Blood Transfusions". The outline of the refresher course, however, will continue to form the general plans for discussion in the coming year.

NORTH VANCOUVER CHAPTER:

Mary Hallam was elected president of North Vancouver Chapter, R.N.A.B.C., at the recent annual meeting. Other officers are: honourary president, Kathleen Lee; past president, Mrs. H. A. MacDonald; vice-president, Mrs. Fred Mitchell; secretary, Frances Lang; treasurer, G. Jones; conveners: social, M. Cameron; membership, Mrs. H. R. Straw, Joan Godfrey; program, Mrs. A. P. McLean; press and publications, Mrs. R. A. McLachlan.

Vancouver General Hospital:

The Alumnae Association of the Vancouver General Hospital has just closed another successful year under the leadership of Mrs. Helen Findlay, president. In December nurses on the hospital staff, who were graduates of other hospitals, were entertained at a very enjoyable party. Money raising projects proved very profitable, a rummage sale realizing $300 while proceeds from a garden party and raffle amounted to over $500. At a Fall meeting members spent the evening packing sixty-four parcels for overseas. V.G.H. graduates. During the year four subscriptions to *The Canadian Nurse* were sent to base hospitals; $900 was contributed to the British Nurses Relief Fund, and $100 to the Red Cross. A loan of $200 was made from the scholarship and loan fund to enable a nurse to complete her university course. Three news-letters were sent out during the year to all V.G.H. graduates of known address. The news-letters, compiled by Dorothy May, serve to keep our graduates far and near informed of hospital and alumnae doings and have brought interesting replies from nurses in many distant corners of the globe.

MANITOBA

BRANDON:

At a regular meeting of the Brandon Graduate Nurses Association our guest speaker was Dr. Payne from the Ninette Sanatorium. He showed illustrated slides and gave an interesting talk on the treatment and control of tuberculosis. We had a good attendance and are now making plans for our final banquet.

NEW BRUNSWICK

MONCTON:

A monthly meeting of the Moncton Chapter, N.B.A.R.N., was held recently with A. J. MacMaster presiding. Special speaker at the meeting was Lulu Johnson who has recently returned from England where she has taught school for the past two years. She gave a delightful talk on her experiences over there. Letters of thanks for Christmas boxes received were read from several nursing sisters overseas. Refreshments were later served by the program committee.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICT 1

The annual meeting of District 1, R.N.A.O., was in the form of a well-attended dinner meeting and was held recently in London, with May Jones, re-elected chairman, presiding. Reports of the various committees were read and showed a very active and fruitful year. We were delighted to have as our guests: Claribel McCorquodale, supervisor of nurses, Department of Radiology and Ontario Institute of Radiotherapy, Toronto General Hospital; Margaret Dulmage, convener of *The Canadian Nurse* circulation for the R.N.A.O.; Gretta Ross, second vice-president of the R.N.A.O.; Marion Stewart, president of the Alumnae Association, Toronto General Hospital; Helen B. Snow, nursing adviser for New York State for the Metropolitan Life Insurance Co.; Florence Walker, newly-appointed associate

secretary, R.N.A.O.; Matron Crossman of Westminster Hospital, who recently transferred her membership from the Maritimes to District 1.

In accordance with the request of the C.N.A., the nurses of this District will observe May 6 as memorial day to pay tribute and honour to the nursing sisters who lost their lives in the last war and in this present struggle.

Plans were discussed for distributing specially prepared posters throughout the District in an effort to aid recruitment for schools of nursing. Miss Dulmage spoke during the afternoon session and in her interesting talk on "The Value of *The Canadian Nurse* to the Nurses of Canada" emphasized and proposed suggestions for increasing circulation. Miss McCorquodale, our guest speaker for the evening, gave an interesting and educational address on the "History and Development of the X-ray" followed by her film entitled "A Nurse Looks at Radiology". This excellent film was compiled by her, and by a series of animations it illustrates what the radiologist sees by means of x-ray, as well as the various duties of the nurse in this department, and also treatment of cancer by means of radium in various ways.

Guests for the dinner and evening included Mr. Arthur Ford, chairman of the Ontario Cancer Treatment and Research Foundation and chairman of Supervisory Commission of the local Cancer Clinic, an original member of the Royal Commission for Control of Cancer in 1931 who has visited cancer clinics in America and Europe; Dr. Ivan Smith, director of the Department of Radiotherapy, London Division, Cancer Committee.

SARNIA:

The graduate nurses association of Sarnia is keenly interested in raising funds for the New Nurses Residence Fund of the Sarnia General Hospital, and $200 was realized from an "evening coffee" recently held at the hospital.

The following graduate nurses of S.G.H. are now serving overseas: Isabel McLean, Pauline DeGraw, Pearl Bloomfield, Margaret Pateman, Daisy King. Annie Frayne is serving with the U. S. forces overseas. Inez Empy and Geraldine Lake are serving with the armed forces in Canada.

The following are taking advanced post-graduate courses: Pearl Woods, obstetrics, Royal Victoria Hospital, Montreal; Marion South, surgery, Toronto Western Hospital; Jean Blacklock, completed course in surgery, Royal Victoria Hospital, Montreal; Mildred Davidson, teaching and supervision, University of Toronto.

LONDON:

A tea was held recently by the Alumnae Association of the Institute of Public Health, University of Western Ontario, in honour of the 1945 graduating class. Many of the nurses attending the recent refresher course

were present and had an opportunity to meet the students whom they will have in the field with them in the near future.

Districts 2 and 3

Brantford:

At a recent well-attended supper meeting of the Brantford General Hospital Alumnae Association Mr. Norman Moore, director of public relations, Cockshutt Plow Co., gave an interesting talk on his trip to Alaska. At the March meeting a post-graduate scholarship was decided upon, to be given by the Alumnae. Plans were made for the Easter dance. Several interesting letters received from nursing sisters overseas have been read at the meetings.

District 4

The 19th annual meeting of District 4, R.N.A.O., was held recently at Hamilton with the chairman, Ada Scheifele, presiding. Among the activities of the past year was the organization of a new chapter at Fort Erie with Mrs. Mabel Goldthorpe as chairman. Florence Walker, the newly-appointed associate secretary of the R.N.A.O., was welcomed to the meeting and spoke briefly. Rev. Norman Rawson gave an interesting account of his experiences while visiting the armed forces overseas.

The officers elected for the ensuing year are as follows: chairman, Ada Scheifele; first vice-chairman, Helen Brown; second vice-chairman, A. Oram; secretary-treasurer, B. Lawson; section conveners: general nursing, A. Lush; hospital and school of nursing, S. Hallman; public health, F. Girvan.

Hamilton General Hospital:

The Alumnae Association of the Hamilton General Hospital held a meeting recently for the purpose of meeting this year's graduating class, who numbered seventy.

District 5

The annual meeting of District 5, R.N.A.O., recently took place in the Royal Ontario Museum, with the chairman, Pearl Morrison, presiding. A membership of 2,552 was reported for 1944, an increase of 379 over 1943. A resumé of reports of chapters, sections, and committees presented at the preceding executive meeting, was given by the secretary-treasurer, Mrs. Jean Williamson. Mrs. A. G. Seabrook, recently returned from England, spoke on "The bravery of women, as seen in the congested east-end of London during the blitz". Music was provided by students from the Toronto Western Hospital.

Preceding the general meeting, the hospital and school of nursing section, under the convenership of Helen McCallum, held a dinner meeting, when an address was given by Jeanette Merry, education officer

of Queen's Institute of District Nursing, London, England.

The following officers were elected to serve during the coming year: chairman, C. McCorquodale; vice-chairmen, J. Wallace, H. Bennett; secretary-treasurer, Mrs. J. Williamson; section conveners: hospital and school of nursing, H. McCallum; general nursing, D. Marcellus; public health, L. Carlis; councillors, M. Winter, G. Jones, T. Green, F. Watson.

DISTRICT 8

Ottawa General Hospital:

At a recent meeting of the Alumnae Association Dr. R. E. Valin gave an interesting and instructive illustrated lecture on "Newer Trends in Colon Surgery".

The following officers were elected for 1945; honourary president, Sr. Flavie Domitille; president, Sr. Madeline of Jesus; vice-presidents, Mmes L. Dunne, E. Chasse; secretary-treasurer, H. Braceland; membership secretary, M. Kryski; councillors, Mmes H. Racine, E. Viau, Misses G. Boland, H. Chamberlain, V. Foran, K. Ryan; representatives to: registry, M. Landreville, E. Bambrick, A. Sanders; sick benefit, J. Frappier; D.C.C.A., M. O'Hare; Red Cross, Mrs. A. Powers; *The Canadian Nurse*, J. Stock.

Under the convenership of Mrs. B. Foley a successful raffle of a $50 Victory Bond was held, the proceeds of which were used for the purchase of a respirator for the obstetrical department of the hospital. A timely and interesting institute on "Ward Administration" was recently conducted at the University of Ottawa School of Nursing by Sister Madeleine of Jesus, director of post-graduate courses.

QUEBEC

Montreal General Hospital:

At the annual meeting of the Alumnae Association held recently, Isabel Davies resigned from the position she has filled so ably as secretary-treasurer of the Alumnae and Mutual Benefit Association. Throughout the years Miss Davies has guided our finances and placed the association on a sound business footing. It was placed on record the appreciation felt by the members of the Alumnae Association and it was further resolved to make Miss Davies a life member in recognition of her services. Helen Morrison, school librarian, was appointed treasurer of the Alumnae and Mutual Benefit Association.

Mrs. T. C. Read (Phyllis Snow) has been appointed instructor at the Western Division. Betty Gardner and Marian Chute have joined the R.C.N. Nursing Service and

among the recent graduates who have joined the staff at the Central Division are: Ruth Willett, Janet Muff, Beulah Hillborg and Nanette Gardiner.

Friends and graduates who have worked with Jennie Webster in the past will be interested to know that she has returned to Montreal to be the guest of M. G. H. for the remainder of her life. Miss Webster receives a warm welcome, not only from her professional associates, but also from the members of the board of management of the hospital, and we are indeed pleased and proud to have Miss Webster back with us again.

Royal Victoria Hospital:

At a recent meeting of the Alumnae Association an interesting talk on "Some of the things that can be done for loss of hearing" was given by Dr. W. J. McNally. Visitors at the school of nursing recently were Matron Margaret Smith and Mrs. Swallow (Helen Moore). Elsie Allder and Winnifred MacLean have left for a period of observation at the Massachusetts General Hospital. Miss Allder and Margaret Etter attended the institute on "Job Instruction" at the McGill School for Graduate Nurses.

SASKATCHEWAN

MAPLE CREEK CHAPTER:

Mrs. Charles Ferris (Clara Schnell, Maple Creek Hospital), who for the past two years has been a nursing sister in South Africa on the staff of a military hospital in Johannesburg, is to make her permanent home in South Africa.

YORKTON CHAPTER:

This Chapter reports having held a very successful meeting, in the form of a banquet, with sixty-four nurses present. Grace Giles, travelling instructor, S.R.N.A., was guest speaker, her topic being "Nurses as Citizens". Miss Giles stressed the importance of all nurses taking an active part in their Association and keeping in touch with nursing activities.

WANTED

Nurses are required for General Duty in the Verdun Protestant Hospital, Montreal. This is a splendid opportunity to obtain psychiatric nursing experience. State in first letter experience, references, etc. and when services would be available. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

WANTED

A qualified Instructress and a Surgical Supervisor are required immediately for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, General & Marine Hospital, Owen Sound, Ont.

WANTED

An Operating Room Nurse is required for a small Cottage Hospital. Write for particulars in care of:

Box 2, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

A Science and Practical Arts Instructor is required for the Victoria Hospital, Prince Albert, Saskatchewan, for September 1, 1945. The salary is $150 per month, with full maintenance. Four weeks vacation and four weeks sick leave with pay each year. Apply, stating particulars, age, and qualifications, etc. to:

Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

WANTED

Two Registered Nurses are required for permanent Night Duty. The salary is $90 per month, plus full maintenance. One full night off each week. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

An Operating Room Supervisor and a Dietitian are required for the Glace Bay General Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

A Registered Nurse, with the necessary qualifications, is required for the position of Assistant Superintendent and Instructress. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Payzant Memorial Hospital, Windsor, Nova Scotia.

WANTED

Registered Nurses are required for **General Duty** in a 100-bed **Sanatorium.** State in first letter date of graduation, experience, references, and date available for duty. Previous experience applied to following salary schedule, plus maintenance: Graduate Nurses who have had no experience — $90 per month; one year's experience — $95 per month; 2 or more years' experience — $100 per month. Apply to:

Miss M. McCort, Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

WANTED

A **Matron** is required for a 30-bed hospital in **Grand'Mère** which is situated about 120 miles from Montreal. Excellent living conditions. Supervisory work only. Knowledge of French preferred. For full particulars regarding salary etc. apply to:

Dr. H. S. Hooper, Laurentide Hospital, Grand'Mère, P. Q.

WANTED

An **Assistant to the Superintendent of Nurses** is required by the **Sherbrooke Hospital.** Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available **immediately.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

General Duty Nurses are urgently required for a 350-bed **Tuberculosis Hospital.** Forty-eight and a half hour week, with one full day off. The salary is $100 per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

Three Graduate Nurses are required for **Summer Relief,** commencing **June 1. Salary: $75** per month and maintenance or $100 and live out. Apply to:

Miss D. Parry, Supt. of Nurses, Children's Memorial Hospital, Montreal, P. Q.

WANTED

A **Night Supervisor,** with some X-ray experience, is required for a 40-bed new hospital. Apply, stating qualifications, to:

Superintendent, Listowel Memorial Hospital, Listowel, Ont.

WANTED

General Staff Nurses are required for the **Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal.** Forty-eight hour week. The salary is $100 per month, plus meals and laundry. Apply to:

Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P.Q.

Official Directory

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Executive Secretary, Miss Anna Schwarzenberg, 1819 Broadway, New York City 23 New York, U.S.A.

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COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Hospital and School of Nursing Section; (3) Chairman, Public Health Section; (4) Chairman, General Nursing Section.

Alberta: (1) Miss Ida Johnson, Royal Alexandra Hospital, Edmonton; (2) Miss B. J. von Gruenigen, Calgary General Hospital; (3) Miss R. E. McClure, Clover Bar Health Unit, Qu'Appelle Bldg., Edmonton; (4) Miss N. Sewallis, 9918-108th St., Edmonton.

British Columbia: (1) Miss G. M. Fairley, 3606 W. 33rd Ave., Vancouver; (2) Miss E. L. Nelson, Vancouver General Hospital; (3) Miss T. Hunter, 4238 W. 11th Ave., Vancouver; (4) Miss J. Gibson, 1035 W. 12th Ave., Vancouver.

Manitoba: (1) Miss L. E. Pettigrew, Winnipeg General Hospital; (2) Miss B. Seeman, Winnipeg General Hospital; (3) Miss L. Miller, 17 Lindall Apts., Winnipeg; (4) Miss J. Gordon, 3 Elaine Court, Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Miss M. Miller, 98 Wesley St., Moncton; (3) Miss M. Hunter, Dept. of Health, Fredericton; (4) Mrs. M. O'Neal, 170 Douglas Ave., Saint John.

Nova Scotia: (1) Miss R. MacDonald, City of Sydney Hospital; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss M. Shore, 314 Roy Bldg., Halifax; (4) Miss M. Ripley, 46 Dublin St., Halifax.

Ontario: (1) Miss Jean I. Masten, Hospital for Sick Children, Toronto; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss M. C. Livingston 114 Wellington St., Ottawa; (4) Mrs. F. Dahmer, 73 Patricia St., Kitchener.

Prince Edward Island: (1) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (2) Mrs. Lois MacDonald, Prince Co. Hospital, Summerside; (3) Mrs. C. H. Beer, 277 Kent St., Charlottetown; (4) Miss Mildred Thompson, 20 Euston St., Charlottetown.

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Holmes was born in Cadiz, Spain. The ship in which his parents were travelling was captured by a French frigate and they were interned there. In 1801 the family arrived at Quebec, later moving to Montreal. Holmes was a pupil of Dr. Arnoldi, later continuing his studies abroad. In the year 1819 he returned to Canada and practised with his former teacher.

A dark man, short and slight in stature, Holmes was slightly stooped. He had a quiet, retiring manner but possessed an abundance of zeal, diligence and alertness. Christian principles characterized his life and he was known and respected for his beliefs.

Much of his free time was devoted to the study of the natural sciences. His extensive collection of the plants of Canada he presented to the Redpath Museum of McGill University. The library of McGill also benefited by his energies and he contributed, in no small measure, to building its collection of books.

Holmes was one of the first physicians in charge of the Montreal General Hospital and a member of its medical board. He was also active in all professional associations and for three years was president of the College of Physicians and Surgeons of Lower Canada.

On October 9th, 1860, Andrew Holmes passed away suddenly. The Holmes Gold Medal awarded for the highest aggregate of marks obtained in the medical course was established in his honour in 1865. The ambition of Andrew Holmes to elevate the practice of medicine in Canada, still further encourages William R. Warner & Company to maintain their policy of Theropeutic Exactness . . . Pharmaceutical Excellence . . . One price and one discount to all.

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Reader's Guide

For many years it has been the policy to have the president of the Canadian Nurses Association be the guest editor and, through her editorial, send greetings to all of the nurses in Canada. It seemed to us that, since the C.N.A. is a federation of the nine provincial associations, it would contribute considerably to the general understanding the nurses in one part of our country would have of the hopes and aspirations, the plans and problems of other parts, if each of the provincial presidents would in turn act as guest editors. To our delight, there was unanimous agreement with this plan, all feeling it was a progressive and democratic step. We have very much pleasure, therefore, in introducing the first of our provincial presidents, **Eileen Flanagan**, who guides the destiny of the Registered Nurses Association of the Province of Quebec. Miss Flanagan was chosen to initiate these editorials since Quebec is this month celebrating its Silver Anniversary.

A native of Quebec, Miss Flanagan, "Flin" to her friends, received her B.A. from McGill University and graduated in 1923 from the Royal Victoria Hospital, Montreal. Later, she took her diploma in teaching and supervision at the McGill School for Graduate Nurses, and had a year as an exchange nurse studying in British hospitals. Today she is supervisor of the Neurological Institute in Montreal.

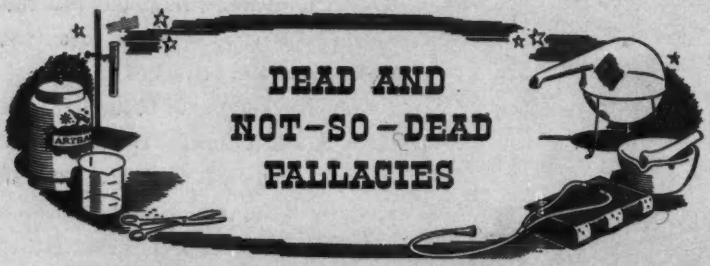
Last winter the nurses of District 8, R.N.A.O., held a refresher course in Ottawa dealing with problems of obstetrical care. **Dr. William J. Stevens** presented one of the papers and we are happy to bring it to our readers in this issue. **Kate McIlraith**, who participated in this same course, is supervisor of the Victorian Order of Nurses in Ottawa. Though not part of the refresher, the points outlined in the article by **Frieda Allum** and **Pauline McKendry** seemed to fit so aptly into this discussion, we would refer you to their description of the prenatal clinic connected with the Royal Victoria Hospital in Montreal.

Mrs. Lois A. Grundy, who is supervisor of nurses, Industrial Health Division, Wartime Shipbuilding Limited, Vancouver, has given us a very interesting account of the routine duties carried on by her staff. During the time when the demand for ships was so great, thousands of older men and hundreds of women who had never before been employed in such strenuous work were inducted into the industry. How these employees were cared for by the Health Division makes not only interesting reading but sets a pattern for this type of service.

Throughout the war years, thousands of persons in Canada have taken courses in first aid to the injured. While our people have been training against a possible emergency, our colleagues in Britain have been experiencing incidents by the hundreds. One of the most important factors in adequate first aid care concerns the treatment of shock. New and different procedures for the care of patients in shock have been evolved and we are indebted to **Miss K. F. Armstrong**, editor of the *Nursing Times*, for permission to reprint her clear analysis of the two reports which have been published on this topic.

The series of articles on supervision in public health nursing which **Mildred I. Walker** has written is concluded in this issue. It has entailed a tremendous amount of work for a busy teacher. As Miss Walker said when she sent in the last article, "Thank God for Sundays!" The series merits close study both by executives and by staff nurses.

Tirelessly, without any fanfare, the Victorian Order nurse brings comfort and healing into the home. Our cover picture is a dramatic illustration of the confidence even the very young have in their ministrations. This photograph won the first prize in a recent contest.



SIR KENELM DIGBY'S Powder of Sympathy, which attracted even the interest of King James, was the remarkable 17th century cure for wounds. A piece of the patient's blood-stained clothing need only be dipped in a solution made from this powder, and the wounds were supposed to heal miraculously.

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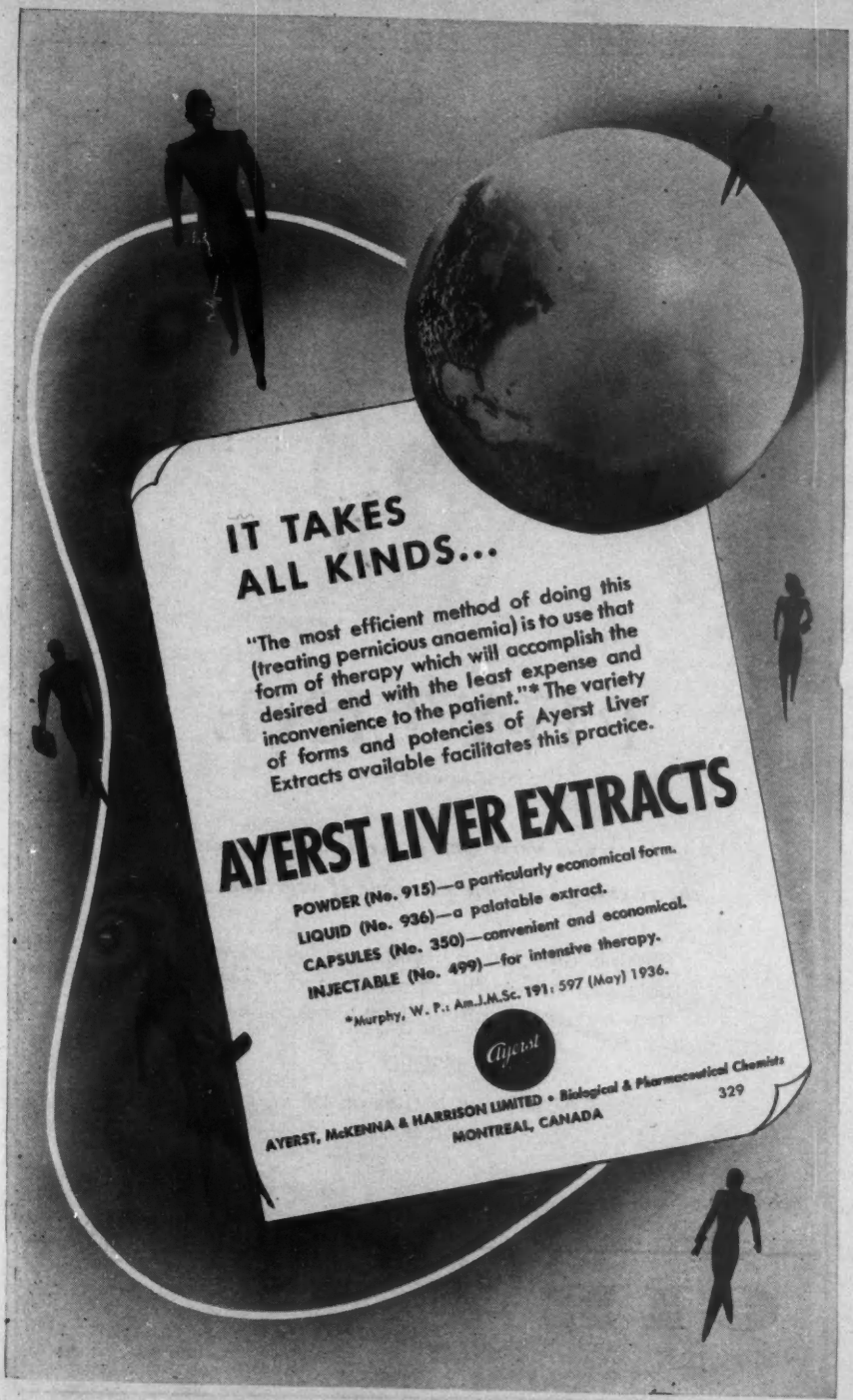
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*Murphy, W. P.: Am.J.M.Sc. 191: 597 (May) 1936.
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ANTISEPSIS

The testimony of the medical press

The first paper on 'Dettol' was published in 1933.* It dealt with only one property of this new antiseptic — its bactericidal power against hæmolytic streptococci; and only one application of this property — the prevention of puerperal infections. In this paper, 'Dettol', on the basis of an investigation at London's great maternity hospital, Queen Charlotte's, was described as more effective than any antiseptic hitherto used in obstetric practice. Within a few months of its adoption as the routine antiseptic, the incidence of maternal infections had fallen by over 50 per cent.

Many confirmatory papers followed, and in a few years it became evident that the uses of 'Dettol' were virtually co-extensive with the whole field of antisepsis. Clinical and laboratory investigations alike attested to the dependability of 'Dettol' in all the contingencies of practice — surgical, medical and obstetric — that called for an antiseptic combining effective bactericidal activity with gentleness to sensitive and wounded tissues, even at full strength.

'Dettol' applied to the patient's skin has been found to confer immunity to reinfection by *Strep. pyogenes* for a period of hours. In the treatment of injuries it has an established place, both because of its sustained activity in the presence of blood and other organic matter and because, unlike the irritant and corrosive phenols and cresols, it leaves the natural mechanisms of healing unimpaired. In conditions calling for repeated antiseptic application it has the advantage that 'Dettol' is non-toxic and, unlike iodine, can be repeatedly applied to the skin. In midwifery practice the 'dettolising' of patient, nurse and practitioner alike has become the most generally practised antiseptic routine.

The special claims of 'Dettol' rest not on one quality alone, but on a combination of qualities to which attention has been repeatedly drawn in papers in the medical and scientific press; above all, on a high bactericidal power against a diversity of organisms (including *Strep. pyogenes*, *Staph. aureus*, *Bact. coli*, and *Bact. typhosum*), non-toxicity, and harmlessness to tissues. Because 'Dettol' embodies in high degree these minimal requirements of a general-purposes antiseptic, it has virtually superseded every other antiseptic in the hospitals of Great Britain; and, because it is so safe and dependable, practitioners never hesitate to recommend it to their patients as the ideal antiseptic for their personal use in the home.

* *Brit. med. J.*, 1933, **2**, 723.

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ADEQUACY

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Even *Junior Tampax* provides amply adequate protection—with its absorptive capacity of 20 cc. for *each tampon*, or 200 cc. for the period (10 tampons are usually considered an ordinary month's supply). In addition, *Regular Tampax* has a capacity of 30 cc., and *Super Tampax* 45 cc. for *each tampon* (or 300-450 cc. for the period).

In a recent study[2] of 110 young nurses employing Tampax tampons for catamenial protection, it was found that "95 per cent used tampons with satisfaction all through menstruation."

In another series[3], 18 (or 90%) of 21 subjects had "complete protection". Also "complete protection was afforded in 68 (94%) of 72 periods reported."

Other clinicians[4], investigating "twenty-five women under close institutional observation", noted that "with a tampon of proper size, absolute comfort and complete control of the flow can be obtained . . . the obvious advantage of the small, medium and large sized tampon of the particular brand (Tampax) is to be noted."

The results of this research parallel the experience of thousands of women who have found that Tampax affords thoroughly adequate protection

(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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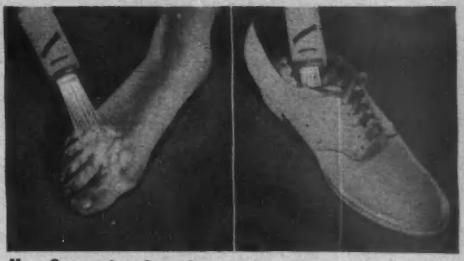
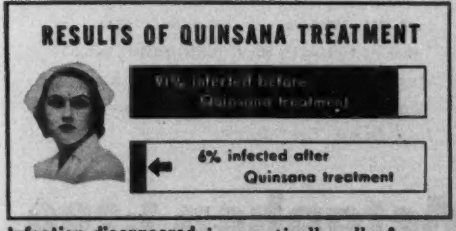
WAR EFFORT SPEEDED BY NEW SUCCESS OVER ATHLETE'S FOOT

Look for symptoms of Athlete's Foot—chronic peeling between toes, cracks, soggy skin, itching.

EVERY NURSE must keep her *feet* in most perfect condition to keep working and marching to victory. But Athlete's Foot is a real threat, as surveys show it infects 7 out of 10 adults—including nurses—sometime during the year. And the disease rages at its worst in the presence of heat and perspiration during summer! Fortunately, a new fungicidal powder—Mennen *Quinsana*—is scoring great successes against Athlete's Foot. Quinsana action is based on knowledge that the fungi which cause the infection cannot live under certain *alkaline* conditions, and may thrive in shoe linings, as well as on feet, creating a vicious circle of *re-infection*.



Use 2-way treatment with Quinsana as regularly as soap and water, to help *prevent* as well as to get quick, effective relief from Athlete's Foot. Even mild cases may suddenly become serious. Inflammation may mean *germ* infection; see physician. (Quinsana is also excellent for excessive perspiration, foot odor). *Pharmaceutical Division. The Mennen Company, Ltd., Toronto, Canada*



Infection disappeared in practically *all* of many test cases among nurses using Quinsana (see chart above). Quinsana is fungicidal, bactericidal, non-irritating, highly absorbent.

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